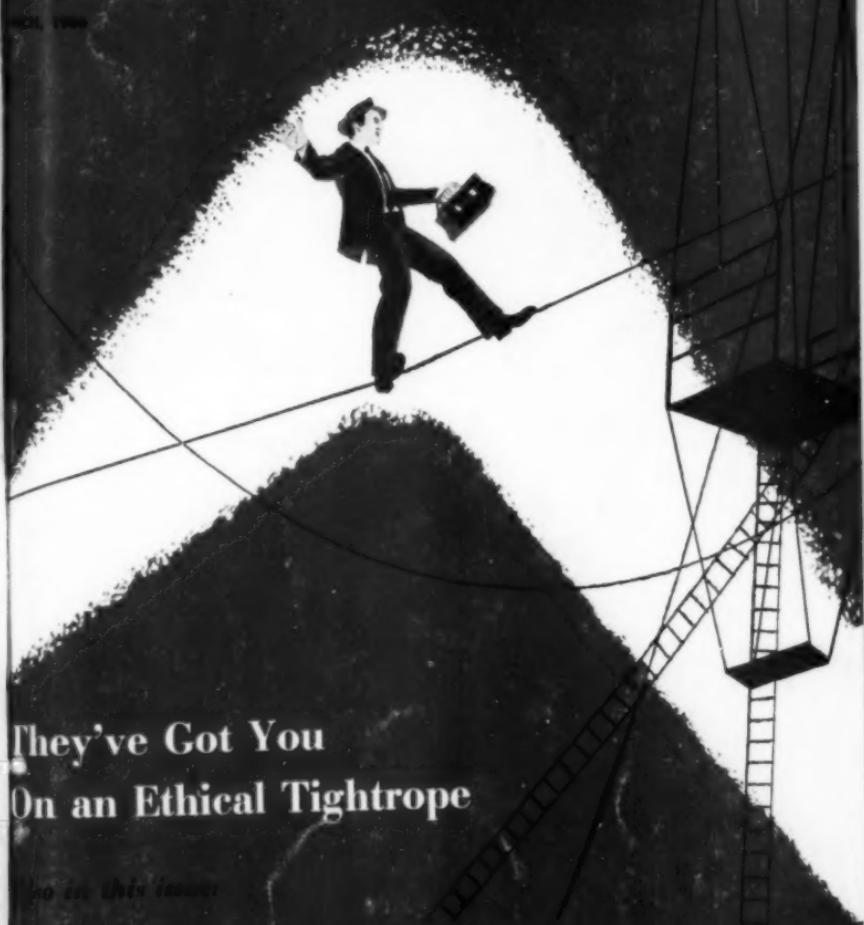


Medical Economics



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J.M.A. Georgia 40:22-4, Jan.
1951. 2. Chamberlain, D.T. Gas-
troint. 17:224-29, Feb. 1951.
3. Dumont, L. Canadian Med.
Assn. J. 69:532, Nov. 1951.

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Memo

FROM THE PUBLISHER

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Medical Economics

AN INDEPENDENT NATIONAL BUSINESS MAGAZINE FOR PHYSICIANS. MAR. 1956

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Published monthly and contents copyrighted 1956 by Medical Economics, Inc., Oradell, N.J. Price 50 cents a copy, \$5 a year (Canada and foreign, \$6). Circulation, 148,000 physicians. Accepted as a controlled circulation publication at the Post Office at Rutherford, N.J.

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Let the National Board of Medical Examiners act as a voluntary agent for the state boards in testing doctors, this writer suggests

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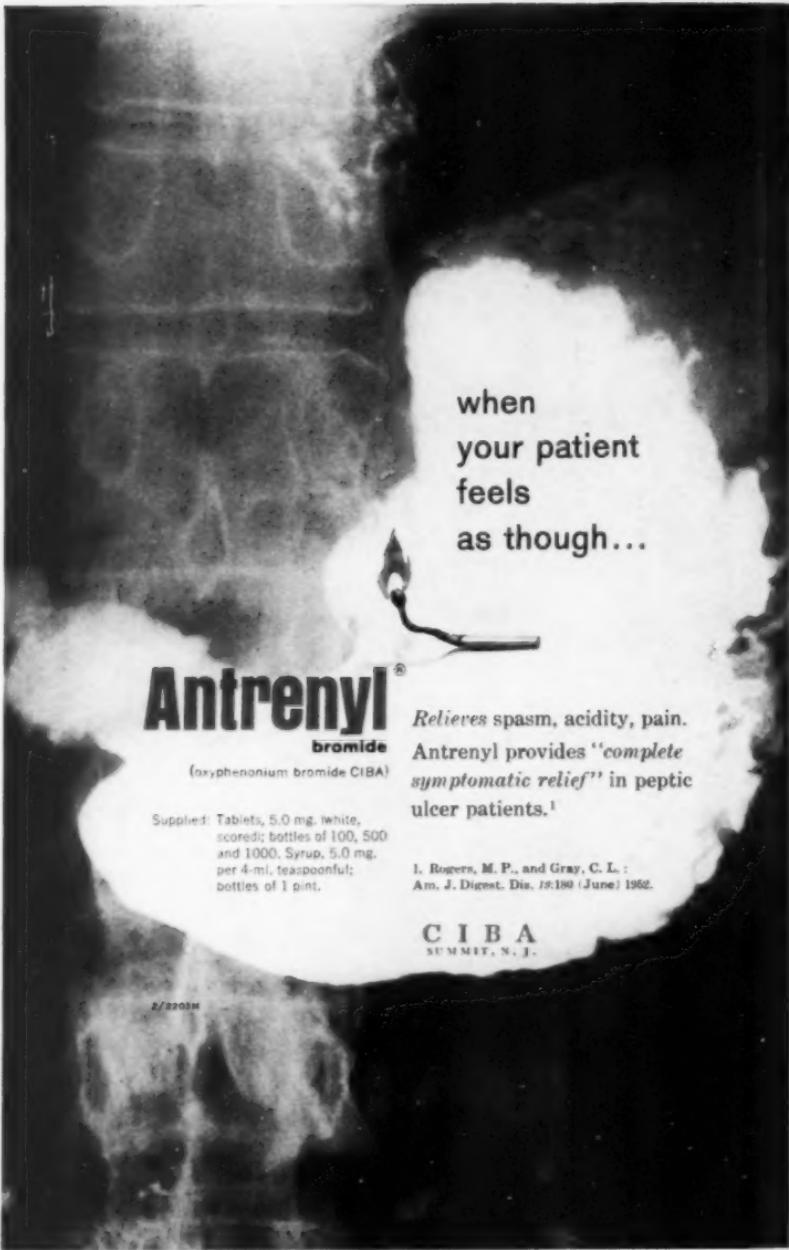
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***When to Call In a Collection Agency* 288**

Want to save trouble? Don't consider turning over those past-due bills until you've made this sixfold test of their 'ripeness'

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¹ Rogers, M. P., and Gray, C. L.:
Am. J. Digest. Dis., 19:180 (June) 1952.

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1. Cronheim, G., and Toekes, I. M.; Comparison of Sedative Properties of Single Alkaloids of Rauwolfia and Their Mixtures, Meet. Am. Soc. Pharmacol. & Exper. Therap., Iowa City, Iowa, Sept. 5, 1955.

2. Moyer, J. H.; Dennis, E., and Ford, R.: Drug Therapy (Rauwolfia) of Hypertension. II. A Comparative Study of Different Extracts of Rauwolfia When Each Is Used Alone (Orally) for Therapy of Ambulatory Patients with Hypertension, A.M.A. Arch. Int. Med. 96:530 (Oct.) 1955.

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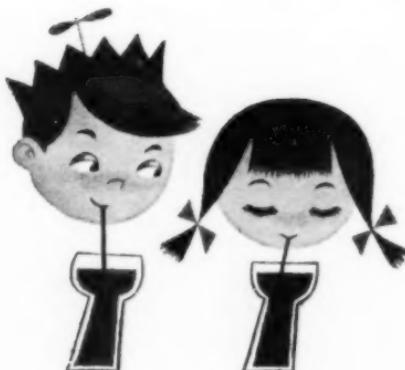


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News

Court compels hospital to readmit

surgeon • Safety belts are saving doctors' lives • Cultists band together for war on 'medical monopoly' • Conservative investing, college style • How to cut your billing time

Treasury Claps Lid on Kintner-Type Plans

Doctors hoping for tax relief on group retirement savings have just been jolted by the Treasury. It recently issued an official ruling that, in effect, says this:

Physicians' retirement funds, as set up by medical groups, have no legal right to the special tax exemption enjoyed by similar funds for corporation employees.

The new ruling stems from a long dispute between the Treasury and Dr. Arthur R. Kintner of the Western Montana Clinic, Missoula, Mont. The dispute began in 1948. In that year the clinic doctors changed their partnership into an association, set up a pension plan for themselves, and claimed that money paid into the retirement fund should get special, tax-exempt treatment.

The Government objected, but the Montana doctors finally won their case in court. In 1954 the

Ninth Circuit Court of Appeals ruled that their pension plan was so set up that it *did* qualify for tax exemption. Legally, this means that other medical groups located in the seven Western states (and three territories) under that court's jurisdiction also have full right to similar tax benefits. So the Treasury will probably think twice before refusing tax-exempt pension privileges to other medical groups in that area.

But the question that remained unanswered was this: Would the Government challenge the legality of such plans set up in other parts of the country? Yes, says the new ruling. Doctors elsewhere who install a Kintner-type pension plan will be forced—like the Montana group—to defend their rights in court.

What's likely to be the effect of the Treasury's statement? Comments one tax consultant: "The prospect of a long-drawn-out court case will probably dissuade most

medical groups from trying for a tax-favored pension plan."

But if group retirement plans have received a setback, *individual* retirement plans may have received a boost. That, at least, is the opinion of Representative Eugene J. Keogh (D., N.Y.), sponsor of a bill that would permit the self-employed to set up their own tax-exempt retirement funds. He is quoted in a Prentice-Hall tax report as follows:

"I think [the new Treasury ruling] will have the effect of helping us get the Keogh bill enacted. Before the ruling was issued, opponents of my measure had been saying that it was really unnecessary in view of the Kintner decision."

Now, Congressman Keogh feels, his proposed tax deferment for self-employed doctors and others is more necessary than ever.

He Capsules the Case For Service Benefits

How do you feel about service benefits in health insurance? Dr. William H. Horton of Connecticut Medical Service feels this way:

"1. If, in the future, the physician expects to be paid, the insurance coverage must do it.

"2. If insurance is to do it, medical fees must be stabilized.

"3. If medical fees are to be stabilized, practicing physicians ought to do it.

"4. If practicing physicians are going to do it, each physician must surrender some of his individuality on behalf of the profession as a whole."

Unless physicians accept the agreed-upon fees as payment in full from people of modest means, says Horton, Congress may eventually decree by legislation what the physicians were unwilling to provide voluntarily."



Horton

A.M.A. Is Said to Show Bureaucratic Symptoms

A.M.A. trustees are currently considering whether to raise A.M.A. dues above the present level of \$25 a year. But one medical leader believes they should consider how to reduce A.M.A. expenses instead.

Speaking as president of the Medical Society of Virginia, Dr. Carrington Williams of Richmond said recently: "It seems to me that serious thought should be given to the re-



Williams

Snapshots

END OF AN ERA: Ten years ago Dr. Channing Frothingham, Michael M. Davis, and others set up the Committee for the Nation's Health. Main aim: to put across national compulsory health insurance. Last month, with its goal further away than ever, the committee quietly decided to disband.

SENTENCED TO PRISON for income-tax evasion, a small-town Kansas physician has been saved by the bell. It was rung by his neighbors, who persuaded the judge to withdraw the sentence because of their community's doctor shortage. The reprieved physician must still pay a \$20,000 fine.

SIX MOST SUCCESSFUL WOMEN of 1955, as selected by *The Woman's Home Companion*, included a distaff-side M.D. who became president of the American Society of Clinical Pathologists. She's Dr. Emma S. Moss of New Orleans.

M.D.-D.O. DEBATE has apparently stimulated young men's interest in osteopathic careers. Applications for admission to osteopathic colleges last fall jumped sharply—up 22 per cent over the year before.

cent expansion of [A.M.A.] activities . . . Its budget has multiplied many times to reach almost five million dollars for the current fiscal year. This expansion compares in proportion too closely to the Federal Government. [As in] the Federal Government, too, numerous bureaus have developed and expanded . . .

"The American Medical Association served us well on a relatively small amount of money until the notable fight against the socialistic Democratic Administrations. [Then it became] necessary to assess each member annually to combat the approach of socialized medicine.

"Like most organizations, the A.M.A. did not release this money when its objective had been accomplished, but now uses it in its expanded activities. It is a situation that should be kept under close observation."

Workers Split 50-50 on Health Plan Choice

In choosing a health plan, which seems more important to the American worker: free choice of physician or comprehensive coverage?

A recent experience of three New York City locals belonging to an affiliate of the International Ladies Garment Workers Union provides a surprising answer:

The locals gave their members

a choice between the Health Insurance Plan of Greater New York (H.I.P.) and Group Health Insurance. The first plan offers nearly complete medical and surgical coverage, with a restricted choice of doctors. The second plan permits free choice of physician, but provides less comprehensive coverage.

Which plan most appealed to the 54,000 workers? Nearly complete returns show about a fifty-fifty split.

Court Orders Hospital To Readmit Doctor

What are the rights of a hospital to exclude a doctor from using its facilities? In the case of a public institution, they're somewhat limited—at least as indicated by a recent decision of the Appellate Division of New York State's Supreme Court.

By a unanimous decision, the court has reversed a lower court ruling on the plea of a surgeon who was ousted from staff membership in, and denied use of the facilities of, a Fulton, N.Y., city hospital. Said the state's highest judicial body:

The hospital was within its rights in denying staff reappointment to the surgeon, because it should have "a free hand . . . with regard to internal management and organization." But his exclusion from use of the hospital's fa-

Snapshots

BLUE SHIELD SUBSCRIBERS are getting more for their money than ever before, latest averages for all plans show. The percentage of plan income paid out in benefits has risen from 77 per cent eight years ago to 83 per cent today. The balance goes into operating expenses and reserve funds.

TRIPLE THREAT: Milwaukee boasts a medical man who can spell "doctor" correctly three different ways. He's an M.D. and a D.D.S., and his name is John P. Docktor.

MECCA FOR QUACKS is California, according to Dr. J. M. de los Reyes of that state's Board of Medical Examiners. "Eastern states with sterner laws put them out of business," he says, "so they come here." His estimate of their annual take: \$100 million.

SPINE MEN WANT IN: No longer satisfied with calling themselves just "doctors," chiropractors are now seeking the legal right to call themselves "physicians." In Iowa, where they've taken the issue to court, this would let them take part in public health programs on the same basis as M.D.s.

NEWS

cilities was "arbitrary and capricious," since the hospital failed to give reasons for such exclusion to either the doctor or the judges.

Therefore, says the court, the surgeon must be allowed to treat his own patients at the hospital: "[Any other decision] would permit the [hospital's] board of governors . . . to convert the hospital into a semi-private one, in accordance with their own notions of what a hospital should be . . . If the right of the general public to use the hospital is to have any meaning, they must have the concurrent right to be treated by their own physicians, unless the latter are excluded for adequate cause."

Doctors Advised to Shun Labor-Industry Talks

When labor and management discuss medical services, should there be a place at the bargaining table for physicians, too? Maryland physicians recently appointed a committee to study the question. The committee's recommendations:

Let labor and industry work out agreements among themselves. Then let doctors decide "individually or as an independent profession" whether or not to accept the proposals. Here's the reasoning behind this advice:

Doctors "as a group are not at all versed[in]the finesse of the bargaining table." Thus the physician

is at a disadvantage in labor-management negotiations.

Besides, even if one physician could "assume the responsibility" of speaking for his colleagues, would others be willing to accept the contract he negotiated? The Maryland committee thinks not.

Political Machine Fleeces Hospital

If your hospital is having a rocky time financially, consider the sad plight of the Jersey City (N.J.) Medical Center: During an eight-year period it was cheated of some \$3.6 million.

An investigation has revealed that the late Frank Hague—Jersey City's mayor of a few years back—and his two immediate successors secretly ordered cancellation of hospital bills owed by their political friends. The bills, it seems, were stamped "uncollectible" or "free service," even though many of the debtors were well able to pay them.

Meanwhile, the hospital was struggling with an average annual deficit of \$4 million.

Safety Belts Save Doctors' Lives

Automobile safety belts are catching on with the medical profession. In one city noted for its high-speed hazards—San Diego, Calif.—more

than 500 of the 750 doctors who drive there have purchased safety belts during the past year.

At least one San Diego physician is very glad he did. His automobile was hit broadside not long ago and turned over twice. His belt saved his life, he reports.

Safety belts are also becoming popular with small-town doctors who have to make long daily trips to the hospital over dangerous

highways. One such man is Dr. Paul Ronniger (*below*), a 39-year-old general practitioner from Brookings, Ore. He has to drive twenty-seven miles to reach his hospital—sometimes as many as three or four times during a single day.

On one recent trip, his car was forced off the road and smashed into a culvert. The car door flew open—but Dr. Ronniger did



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Lederle

not fly out. The safety belt he'd installed for \$24 held him fast, and he got off with a bloody nose and some bruised ribs.

Cultists Unite for War On 'Medical Monopoly'

The nation's nonmedical "healers" have now linked hands under one banner. They've formed a non-profit corporation—the National Health Federation—to give "the public and the progressive and nonmedical professions . . . a powerful, organized voice to speak in their behalf in matters of health."

Why does the public need such a voice? Because the Food and

Drug Administration, the A.M.A., and other members of a "medical monopoly [are] reaching into every household of the land seeking to destroy . . . that which does not conform to accepted medical opinion." So says the new federation.

Guiding the organization will be a twenty-seven-man board of governors. Packed with chiropractors, the board as so far constituted also includes a naturopath, a dentist, and a doctor of divinity. Among other things, these men plan to:

¶ Ask Congress to investigate "healing in the United States, to determine if organized medicine and allied groups have created a monopoly in this field." [MORE ▶]

Through The Menstrual Years of Life-

THE frequency with which the menstrual life of so many women is marred by functional aberrations that pass the borderline of physiologic limits, emphasizes the importance of an effective uterine tonic and regulator in the practicing physician's armamentarium.

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NEWS

¶ Support legislation that would eliminate "discrimination between classifications of licensed healers."

¶ Oppose fluoridation as "a giant plot fraught with grave dangers to the general health."

¶ Wage war against the "gestapo [inspection] methods" of food and drug inspectors.

Growing Pains Afflict Major Medical Plans

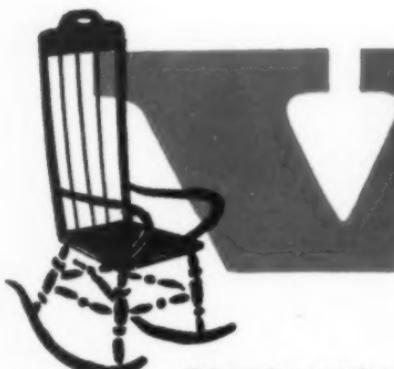
Major medical expense insurance continues to grow by leaps and bounds. At the beginning of 1956, some 4 million Americans carried major medical policies of one kind or another—a jump of more than

80 per cent in just twelve months.

What's more, the country's commercial carriers expect the trend to continue. Edmund Whittaker, a vice president of the Prudential Insurance Company, recently told The Wall Street Journal that within ten years 100 million Americans would probably own such insurance.

But, as they flourish, major medical plans are presenting some knotty problems to the insurance companies, says the Journal. Among the chief sources of trouble:

¶ *Hypochondriacs.* "[They] really stung us," an official of Royal Liverpool is quoted as saying. Un-



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"For which the first was made..."

—Robert Browning

Each VASTRAN tablet contains:

Nicotinic Acid	50 mg	the
Ascorbic Acid	100 mg	poor ap-
Riboflavin	5 mg	pears
Thiamine Mononitrate	10 milligrams, re-	lief
Pyridoxine HCl	1 mg	arrowwi-
Vitamin B ₁₂	2 mcg	ng

supplied:

Bottles of 100 and 500 scored tablets

Each cc. of VASTRAN AMP Solution contains:

Nicotinic Acid	20 mg	cerebra
Vitamin B ₁₂	75 mcg	and thym-
Adenosine-5-Monophosphoric Acid	25 mg	bright

supplied:

5 cc. Sterile Vials

Wampole LABORATORIES

like most companies, Royal Liverpool writes only individual policies. Many of the commercial insurers try to avoid the hypochondriac problem by concentrating on the sale of group contracts.

Well-to-do policyholders. Such persons generally demand more expensive medical care than do less prosperous individuals. So naturally their claims are higher. As a result, Royal Liverpool now refuses to insure anyone with an annual income of more than \$40,000. Another company that issues only individual contracts has slapped a \$25,000 annual income limit on its policyholders. And even group-writing New York Life

Insurance Company is considering the imposition of some such ceiling.

City dwellers. Most major medical insurance is sold to residents of large cities, where medical costs are highest. To offset such risks, at least one company is making a sturdy effort to sell more insurance in small towns and rural areas.

Conservative Investing, College Style

What are money-cautious colleges doing with their assets these days? They're investing an average 56 per cent [MORE ON 306]

TO MAINTAIN CEREBRAL VITALITY, ARREST GERIATRIC SLOWDOWN

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TABLETS
AMP
(intramuscular)

ins:
50 m in the aging patient, the familiar symptoms of fatigue, apathy,
100 m poor appetite, etc., usually signal Geriatric Slowdown. Cause, in most
5 m cases, reduced cerebral metabolism, resulting from (1) sclerosis and
10 m narrowing of the lumen of brain arteries and (2) incomplete
1 m cerebral nutrition. Unsatisfied, the imperative oxygen needs of the
2 m brain permit the patient to slip into retirement from life on all fronts.
tablets
Solutions
VASTRAN®, vasodilator-metabolic stimulant, provides a new approach
to management of Geriatric Slowdown. With nicotinic acid to increase
20 m cerebral circulation, plus coenzymes to stimulate metabolism in the brain
75 m and throughout the body, VASTRAN® therapy affords the older patient
25 m a brighter outlook, plus the physical vitality to follow through.

Eamples and literature on request

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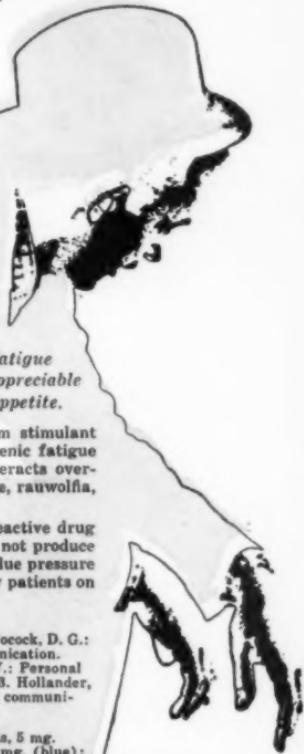
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*Lift the depressed patient up to normal
without fear of overstimulation . . .*

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IN PSYCHOMOTOR
STIMULATION



- Boosts the spirits, relieves physical fatigue and mental depression . . . yet has no appreciable effect on blood pressure, pulse rate or appetite.

Ritalin is a mild, safer central-nervous-system stimulant which gently improves mood, relieves psychogenic fatigue "without let-down or jitters" . . .¹ and counteracts oversedation caused by barbiturates, chlorpromazine, rauwolfa, and antihistamines.

Ritalin is "a more effective and less over-reactive drug than amphetamine or its derivatives."² It does not produce the "palpitation, nervousness, jitteriness, or undue pressure in the chest area . . . so frequently mentioned by patients on [dextro-amphetamine sulfate]."²

Dosage: 5 to 20 mg. b.i.d. or t.i.d., adjusted to the individual.

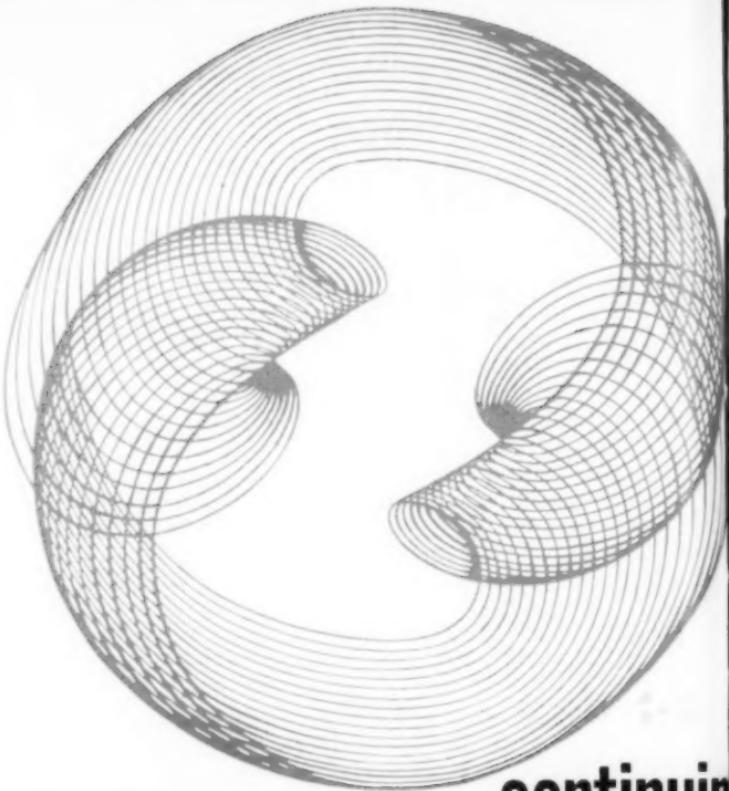
RITALIN® hydrochloride
(methyl-phenylacetate
hydrochloride CIBA)

References: 1. Pocock, D. G.: Personal communication.
2. Harding, C. W.: Personal communication. 3. Hollander, W. M.: Personal communication.

Supplied: Tablets, 5 mg. (yellow) and 10 mg. (blue); bottles of 100, 500 and 1000. Tablets, 20 mg. (peach-colored); bottles of 100 and 1000.



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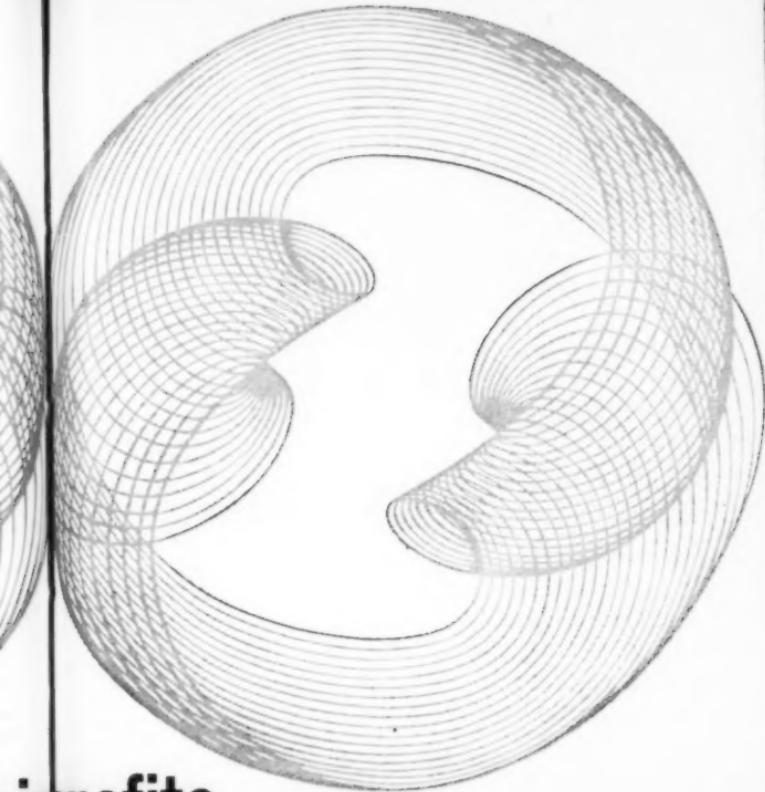
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past 40
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Rehfuss¹ has stated that after 40, constipation is "the greatest single medical problem" and Shaftel² reports on the exceptional clinical results of Caroid® and Bile Salts in chronic constipation typical of this age bracket.

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CAROID AND BILE SALTS tablets

1. Rehfuss, M. E.: Indigestion, Philadelphia, W. B. Saunders Co., 1943, p. 322.
2. Shaftel, H. E.: J. Am. Geriatrics Soc. 1:549 (Aug.) 1953.

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widely prescribed because of these important advantages:

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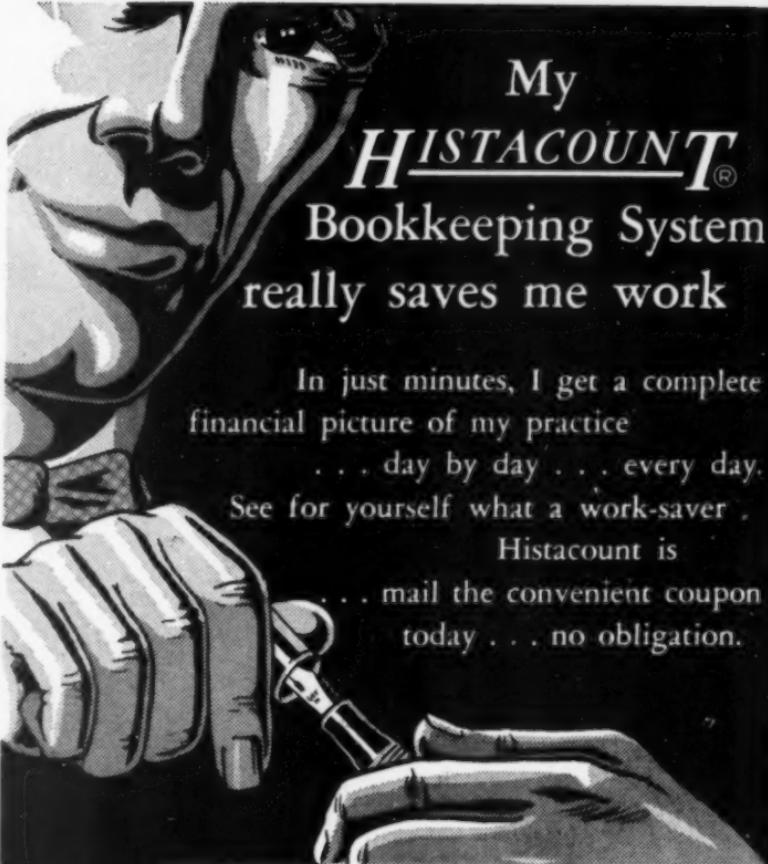
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ANALGÉSIQUE

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Lange and Weiner suggest the term "hyperkinetics" to describe preparations such as BAUME BENGUÉ which produce blood flow *through a tissue area*. They point out that hyperkinetic effect, as measured by thermoneedles, may extend to a depth of 2.5 cm. below the surface of the skin. (J. Invest. Dermat. 12:263, May, 1949.)

Two strengths: regular and children's.

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Menthol-induced hyperemia plus high local concentration of salicylate has been rediscovered as one of the most promptly effective remedies for rheumatoid discomfort due to exposure.



the only broad spectrum antibiotic preparation that:

1 provides the antimicrobial activity of tetracycline

Because it contains Steclin (Squibb Tetracycline), the well-esterated broad spectrum antibiotic, MYSTECLIN is an effective therapeutic agent for many common infections. Most pathogenic bacteria, as well as certain large viruses, certain Rickettsiae, and certain protozoans, are susceptible to Mysteclin.

2 protects the patient against monilial superinfection

Because it contains Mycostatin (Squibb Nystatin), the first and most effective antifungal antibiotic, MYSTECLIN acts to prevent monilial overgrowth frequently observed during broad spectrum antibiotic therapy. Manifestations of this overgrowth may include some of the diarrhea and anal pruritus associated with antibiotic therapy, as well as vaginal moniliasis and thrush. On occasion serious and even fatal infections caused by monilia may occur.

Mysteclin

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(SQUIBB TETRACYCLINE • NYSTAT)

"MYSTECLIN", "STECLIN" AND "NYCOSTAT"® ARE SQUIBB TRADEMARKS

A PARTIAL LIST OF INDICATIONS
FOR MYSTECLIN

When caused by tetracycline-susceptible organisms, the following conditions are among those which may be expected to respond to Mysteclin:

Abscess	Metritis
Bronchiectasis	Osteomyelitis
Bronchitis	Otitis Media
Bronchopneumonia	Peritonitis
Burns, Infected	Pertussis
Cellulitis	Pharyngitis
Cervicitis	Pinworm Infestation
Chancroid	Pneumonia
Colitis	Psittacosis
Cystitis	Pyelonephritis
Diarrheas, Infectious	Q Fever
Diphtheria	Rocky Mountain Spotted Fever
Dysentery, Amebic	Salpingitis
Dysentery, Bacillary	Scarlet Fever
Empyema	Scrub Typhus
Endocarditis, Bacterial	Sepsis, Puerperal
Erysipelas	Septic Sore Throat
Furunculosis	Septicemia
Gangrene	Sinusitis
Gastroenteritis	Skin Graft Infections
Gonorrhea	Surgical Prophylaxis
Granuloma Inguinale	Tonsillitis
Klebsiella Pneumonia	Tracheobronchitis
Laryngitis	Tularemia
Lymphadenitis	Typhoid Fever
Lymphangitis	Typhus
Lymphogranuloma Venereum	Urethritis
Mastoiditis	Vesiculitis
Meningitis	Vincent's Infection
	Wounds, Infected
	Yaws

It is impossible to predict with certainty in which patients clinical moniliasis may develop as a result of broad spectrum antibiotic therapy. However, the added protection afforded by Mysteclin against monilial superinfection is especially important in patients who are debilitated, elderly, or diabetic, or when antibiotic therapy must be prescribed in high dosage or for prolonged periods. It is also important in infants (particularly prematures), as well as in patients for whom concomitant cortisone or related steroid therapy is prescribed, or in subjects who have developed a monilial complication on previous broad spectrum therapy.

Mysteclin is particularly useful in women, inasmuch as they not infrequently develop vulvovaginal moniliasis after treatment with ordinary broad spectrum antibiotics; this is especially common in women who are pregnant or diabetic.

MYSTECLIN Capsule
250 mg. Steclin
Tetracycline Hydrochloride
1000 units Mycostatin
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STAT: An adult dose: 2 capsules q.i.d.
STAT: Bottles of 12 and 100.

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1. Selling, L. S.: J.A.M.A. 157: 1594, 1955. 2. Borrus, J. C.: J.A.M.A. 157: 1596, 1955.

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the original meprobamate—2-methyl-2-n-propyl-1,3-propanediol dicarbamate—U. S. Patent 2,724,720

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Literature and Samples Available On Request



Letters

Why some licensure laws

are strict • The G.P.s discuss their problems • Giving your aide instructions • Should professional courtesy be abolished? • In defense of the hospital administrator

Social Security

SIRS: . . . Compulsory Social Security coverage is financially unsound. A 1954 report of the House Ways and Means Committee proved that this is so. But, like any other type of governmental compulsion, it's also *philosophically* unsound . . .

How far are we prepared to go along with the paternalistic Government that says, "We know better than you what's good for you. Do as we say—or else!"? What recourse do the people have if the planners should be wrong? Can they, for instance, bring suit for malpractice?

And what's to be done with that dangerous creature, the rugged individualist, who insists on deciding for himself what's good for him and what isn't? We know what is happening to him in the paradise of the proletariat. Will the Washington humanitarians always be satisfied with the fines and jail sentences now imposed on those

who fail to pay Social Security taxes?

Lyon Steine, M.D.
Valley Stream, N.Y.

SIRS: There's every reason to believe that if doctors were polled individually, well over 50 per cent would vote in favor of inclusion in the Social Security program . . .

H. Fielding Wilkinson, M.D.
Hollywood, Calif.

SIRS: Even the Government can't make money out of thin air. It has to collect its funds from the pockets of its citizens. For that reason, it seems to me that Social Security coverage would be beneficial only under two conditions: first, if it provided cheaper and more efficient management of the funds collected; second, if those covered were so stupid that they had to be forced by law to save for their old age.

All doctors will agree, I think, that private insurance and invest-

comprehensive, well-balanced

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Vitamin A 1670 U.S.P. Units		Iron (FeOx endocaps)	3.24 mg.
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Triamrine Mononitrate (B.i.)	1 mg.	Phosphorus (CaH ₂ PO ₄)	
Riboflavin (B ₂)	1 mg.	Iodine (KI)	0.06 mg.
Niacinamide	20 mg.	Vitamin C (CaAsP)	0.1 mg.
Calcium Pantothenate	0.34 mg.	Copper (CuSO ₄)	0.1 mg.
Pyridoxine HCl (B ₆)	0.34 mg.	Potassium (K ₂ CrO ₄)	5 mg.
Folic Acid	0.34 mg.	Manganese (MnO ₂)	1 mg.
Vitamin B ₁₂	0.34 microg.	Zinc (ZnO) 0.5 mg.	
Ascorbic Acid (C)	26 mg.	Magnesium (MgO)	1 mg.
		Boron (Na ₂ B ₄ O ₇)	0.1 mg.

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LETTERS

ment companies are managed more efficiently than our national bureaucracy. And no physician needs to be forced to save . . .

J. Ramunis, M.D.
Chicago, Ill.

SIRS: No one would dispute the statement of the A.M.A.'s Board of Trustees that it's "incompatible with the free enterprise system for a group to be compulsorily covered under a governmental system of old age benefits when that group strongly opposes such coverage." But it is disputable that the majority of self-employed physicians really do oppose coverage. A number of county medical societies, after discussing the costs and benefits, have endorsed compulsory Social Security for doctors . . .

Harold Aaron, M.D.
New York, N.Y.

Licensure Laws

SIRS: Anyone reading Greer Williams' article, "Licensure: It's a Mess!" would think that we Florida doctors are a bunch of narrow-minded xenophobes who are pig-headedly determined to preserve our medical monopoly. This isn't true. There's a good reason why we won't endorse or reciprocate licenses from other states.

If we didn't use some discretion, we'd be flooded every winter by Northern physicians who want to pay for their vacations by doing a

little medicine on the side. And we'd face competition from the many doctors who come to Florida to retire and who would like to pick up some odd change by seeing a few patients now and then.

It's harder to get a medical license than a fishing license in my state. And we intend to keep it that way.

M.D., Florida

Patients, Not 'Buddies'

SIRS: Public relations experts are always telling us we ought to have a "reciprocal" or "mutual" relationship with our patients. But let's face it: The doctor-patient relationship can't—and shouldn't—be a companionable arrangement.

The patient comes to the doctor with the hope of being relieved of pain or of fear. He comes with a prayer in his heart or on his lips. This is not the posture of "mutuality." A doctor who converts this relationship into a back-slapping "buddy" partnership is cheapening a fine and subtle bond.

Henry A. Davidson, M.D.
Cedar Grove, N.J.

G. P. Talk

SIRS: When a phone book lists doctors by specialty, the G.P. suffers by comparison . . . Instead, the books should list all G.P.s as capable of doing medicine, surgery, obstetrics, and so on. This would make it clear that, in any sort of

LETTERS

medical emergency, the best man to call is a G.P.

Bernard Zuckerman, M.D.
Milford, Conn.

SIRS: I read with considerable interest "G.P.s Want Fairer Share From Blue Shield." It's true, as the author says, that the general practitioner (as well as the pediatrician and the internist) is the forgotten man in practically all voluntary health insurance plans . . .

Group Health Insurance, Inc., (of which I am medical director) has tried to remedy this discrepancy. Participating general practitioners are paid in full, on the basis of a medical fee schedule set

up with the help of the A.A.G.F. Where services are rendered by a G.P. and a surgeon, the surgical fee is prorated if both doctors submit claim forms . . .

Arthur A. Fischl, M.D.
New York, N.Y.

SIRS: The G.P.s are done for! They'll soon take their place in the glass-enclosed cage next to the dodo. They're being replaced by mechanized medicine in the guise of philanthropic health insurance.

If I sew up a laceration in my office, Blue Shield pays me nothing. If I sew it in the hospital, they allow me a certain fee. So the patient insists I do it in the hospital.

[MORE ▶]

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'Seconal Sodium'

(SECOBARBITAL SODIUM, LILLY)

Distinguished for prompt onset of action;
short duration of effect.

Supplied in pulvules, ampoules, suppositories, powder, and 'Enseals' (Timed Disintegrating Tablets, Lilly).



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use PROTAMIDE® first
in herpes zoster and post-infection neuritis



*Combes, F. C. & Canizares,
O.: New York St. J. Med.
52:706, 1952; Marsh,
W. C.: U. S. Armed
Forces M. J. 1:1045, 1950.

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Evaporated or Powdered, Meyenberg (the original)
Goat Milk is a natural milk likely to give prompt control
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curd . . . will not cause the diarrhea often
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Meyenberg Goat Milk is nutritionally equivalent
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Since 1934

But what of the physician who has no hospital privileges? What patient is crazy enough to go to that doctor's office?

Soon we G.P.s will get only the scut work that the surgeon can't or won't do. I don't know who will pay us, though. More and more patients are saying, in effect, "If you can't collect from my health plan, that's your tough luck!"

Erwin Arnovitz, M.D.
Duquesne, Pa.

Industrial Training

SIRS: The author of your recent article, "New-Type Training Is Offered for Part-Time Work in Industry," implies that the Milwau-

kee post-graduate course in industrial practice is a new idea. I'd like to point out that the Medical Extension Division of U.C.L.A. has been presenting a similar course for the past two years . . .

Fred A. Bryan, M.D.
Los Angeles, Calif.

Suture Convenience

SIRS: I'm surprised that any doctor should advocate—as one of your correspondents did recently—that a nurse be asked to sew up the skin after an operation. No surgeon who has any sense of legal and moral responsibility will allow anyone but another doctor to assist him . . .

[MORE ▶]

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MEDICAL ECONOMICS · MARCH 1956 45

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ME I

LETTERS

If nurses started taking over the assistant's duties, where would you draw the line?

Donald D. Brusca, M.D.
Islip, N.Y.

The Aides Speak Up

SIRS: I agree with Frances L. Marold, author of "What You Don't Know About Your Aide," that the secretary needs to have well-defined responsibilities. My employer has given me explicit instructions on every phase of my work. For example, he's given me a list of answers to simple medical questions ("How often is it safe to take aspirin?" "When should I bring Susie in for a booster shot?") that patients often ask over the phone.

I also have instructions on how to answer outsiders' questions about a patient's health. "I really don't know," I tell them. "The doctor never discusses his patients with me." If this doesn't stop the interrogation, I say: "Well, Mrs. Jones, if someone asked me what was wrong with you—and if I knew—you wouldn't want me to make it public, would you?"

That answer works every time.

Marjorie Oberling Marbach
Tinley Park, Ill.

SIRS: ... Miss Marold should have put more emphasis on the role of the doctor's wife. Many aides tell me they get upset—and rightly so—when their employers' wives drop in to rearrange the furniture and



*an outstanding contribution
to modern therapy*

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... the new injectable anti-inflammatory enzyme—chymotrypsin

specifically indicated in

Chronic ulcers (stasis, varicose and diabetic)
Reduction of hematomas—to hasten
absorption
Swelling due to trauma
Cellulitis
Bursitis and arthritis
Phlebitis
Inflammation of the eye (iritis, iridocyclitis,
chorioretinitis, uveitis)

safe

- ... no systemic side effects
- ... rarely painful on injection
- ... small therapeutic dosage—non-toxic—
economical
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mechanism—no clotting time or serum
protein determinations necessary
- ... no known incompatibilities, may be
administered concurrently with anti-
biotics, ACTH or adrenal steroids
- ... no known contraindications

Each 1 cc. contains 5000 units of
proteolytic activity of chymotrypsin
Supplied in 5 cc. vials.



THE ARMOUR LABORATORIES
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LETTERS

tell them how to run the office. Thank goodness I don't have this problem! . . .

Carolyn Horvath
Warrensville Heights, Ohio

Sirs: I was deeply touched by the heart-rending tale of woe recently recounted in your Letters department by a Manhattan doctor's aide. Like her, I work long hours and have to buy my uniforms out of my small pay check.

But at the risk of sounding idiotic, I must confess that when I see the look of gratitude in patients' eyes as they say good night to my boss, I feel that my rewards far exceed any monetary gain.

The girl who wants regular hours, routine work, and high wages can find a job operating a machine in a stainless-steel factory. As for me, I'll stick to the pains and pills, pleasures and penurious pay that go with working for a man I respect.

Deborah L. Smith
Upton, Mass.

Medical Society Ban

Sirs: It's not true, as a spokesman for the Los Angeles County Medical Association asserted recently, that a doctor's right to practice in the state is in no way affected by the society's decision to bar him from membership. [MORE ▶]

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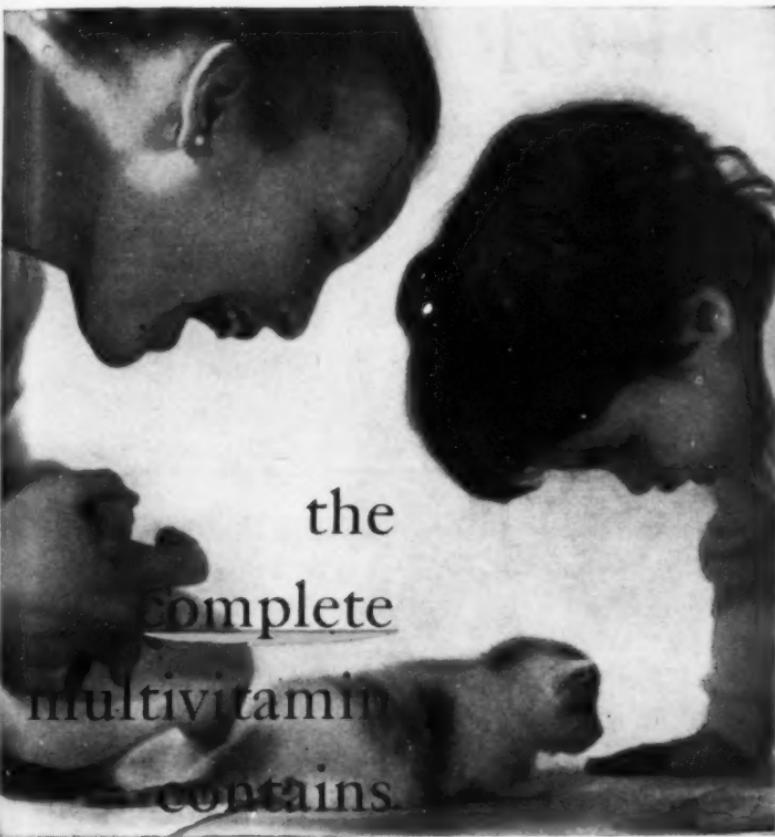
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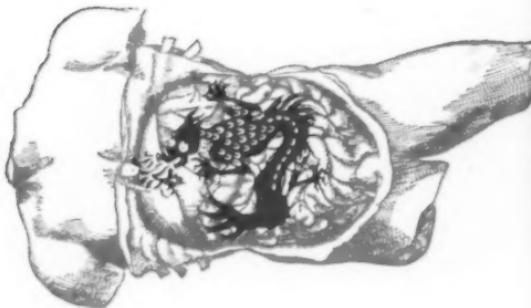
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in many gastrointestinal disorders

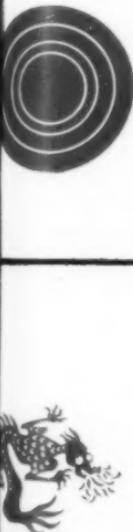
THORAZINE*

"would appear to be the tranquilizing agent of choice . . ."



"Thorazine" is available, as the hydrochloride, in ampuls,
tablets and syrup; and, as the base, in suppositories.

*T.M. Reg., U.S. Pat. Off. for chlorpromazine, S.K.F.



in many gastrointestinal disorders . . .

. . . functional as well as secondary to organic disease such as spastic colon, peptic ulcer and a variety of other conditions marked by pain and vomiting, 'Thorazine' has 3 advantages:

-
1. 'Thorazine' abolishes the emotional turbulence—fear, excitation, anxiety, tension—that adversely affects digestion and the digestive tract.
 2. 'Thorazine' effectively controls the nausea and vomiting associated with gastrointestinal disorders.
 3. 'Thorazine' has a mild atropine-like, inhibitory effect on gastric secretion and "would appear to be the tranquilizing agent of choice when stimulation of gastric secretion is contraindicated."¹
1. Haverback, B.J.; Stevenson, T.D.; Sjoerdsma, A., and Terry, L.: The Effects of Reserpine and Chlorpromazine on Gastric Secretion, Am. J. M. Sc. 230:601 (Dec.) 1955.

Smith, Kline & French Laboratories, Philadelphia

LETTERS

I know. For twenty years I have been suffering under such a ban.

M.D., California

Automobile Safety

Sirs: Since car manufacturers are emphasizing safety these days, why haven't they redesigned front ends to absorb the shock of high-velocity impact? Bumpers *used* to act as shock absorbers, before they were degraded into mere gaudy decorations on today's "jukeboxes on wheels."

Alfred Rosskamm Ross, M.D.
Belfast, N.Y.

Sirs: ... One automotive engineer has been quoted as saying, "We

don't design cars—the public designs them."

The manufacturers will make additional improvements only if they're convinced they can make more money by selling safety as well as glamour.

R. Arnold Griswold, M.D.
Louisville, Ky.

Professional Courtesy

Sirs: You report that some doctors have enrolled in Blue Shield to avoid the "embarrassment" of asking for professional courtesy . . . Apparently they think it perfectly ethical for a physician to accept money from a go-between, though he still can't take it directly from a



FOR HARD, DRY STOOLS OF *Constipated Babies*

Borcherdt

MALT SOUP *Extract**

A gentle laxative modifier of milk. Just 1 or 2 tablespoonsfuls in day's formula softens stools, usually over night. Promotes aciduric bacteria. Grain extractives and potassium ions contribute to gentle laxation. Safe and easy to use.

GOOD FOR GRANDMA, TOO!

Especially valuable for thin, under-par elderly patients with hard, dry stools. Supplies nutritional factors from rich barley malt. DOSE: 2 Tbs. A.M. and 2 Tbs. P.M. until stools are soft, then 1 or 2 Tbs. P.M. Take in coffee or milk.

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the double-action
concentrated
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Pint Boxes: 1/2 Gallons
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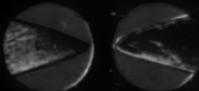
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Scalpel immersed in ordinary germicide
6 months it is pitted, dull. Scalpel in C.R.I. 6 months
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Order from your dealer. He also stocks: Autoclips and Applier • Franklin Bilirubin Test
Cantor Tube • Medicchromes • Kahn Trigger Cannula • Intramedic Polyethylene Tubing

LETTERS

colleague. This seems to me rather hypocritical.

But if we *must* be hypocritical rather than Hippocratic, why can't we extend our group insurance to cover all home and office care, as well as hospital treatment? Then we'd never feel hesitant about asking for medical attention.

M.D., Pennsylvania



bottled in bond

When overindulgence is the cause of gastric distress, consider BiSoDoL Mints for your patients. BiSoDoL Mints help restore a normal pH quickly, without acid rebound, without constipating effects so common to other antacids. BiSoDoL Mints are a well balanced combination of Magnesium Trisilicate, Calcium Carbonate and Magnesium Hydroxide, proved most effective for relief from hyperacidity. BiSoDoL Mints are pleasant to take too. Remember BiSoDoL Mints.

fast-acting **BiSoDoL** mints

(contain no baking soda)

WHITEHALL PHARMACEUTICAL COMPANY • NEW YORK, N.Y.

SIRS: A colleague of mine once told me he'd got tired of being "fitted in" when he consulted a doctor who knew he was a medical man. On one occasion, he said, a dermatologist unquestioningly accepted his tentative diagnosis of a skin condition. Without bothering to make an examination, the specialist merely suggested a treatment from the textbook.

So, my friend said, he now seeks treatment only as a paying patient. He makes an appointment under an assumed name, arrives a little early, and pays the aide in advance. Sometimes the disguise is penetrated, and the treating physician may protest a little. But never once has the fee been refunded.

Herman Goodman, M.D.
New York, N.Y.

Hospital Management

SIRS: As administrator of the Hackensack Hospital Association, I'm convinced that Dr. Avery Compton's article, "What Ails Our Hospitals?" gives a false picture of the management in most institu-

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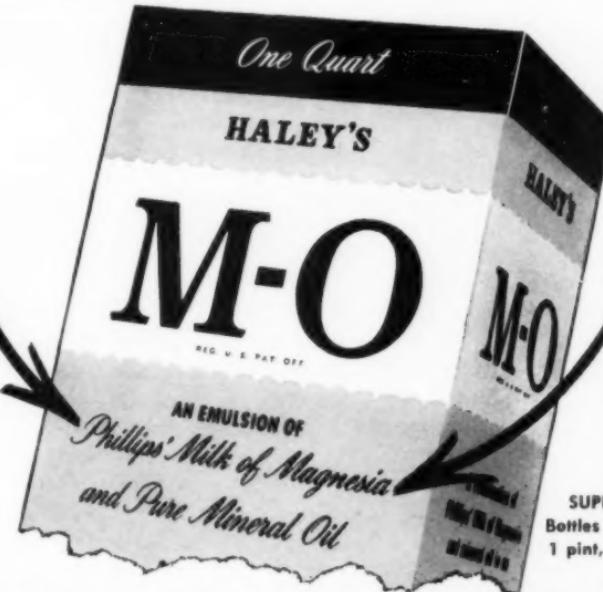
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TO HELP CORRECT CONSTIPATION

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Magnesium Hydroxide plus pure mineral oil make Haley's M-O a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and the attendant gastric hyperacidity.

The oil globules in Haley's M-O are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is avoided and a comfortable evacuation is effected through stimulation of normal intestinal rhythm and blunted defecation reflex.



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MEDICAL ECONOMICS • MARCH 1956 55

LETTERS

tions. For one thing, it leaves the impression that hospitals were better managed before World War II than they are now.

Actually, the changes since 1940 have come about because there was a public hue and cry for more businesslike management. So the various governing boards decided to take hospital administration away from physicians and to put it in the hands of better qualified persons . . .

The author says that the administrator of his hospital "spends only part of about two days each week there." If this is so, there are many administrators who would gladly apply for his job. Most of the men

I know find it impossible to perform all their duties in a forty-hour week. They spend a good many off-duty hours at their hospitals.

Martin S. Ulan
Hackensack, N.J.

SIRS: Substitute "professor" for "physician" in Dr. Compton's article and you'll have a good picture of many universities today. Here, too, the administrator is in complete command.

This state of affairs has been brought about by the professional man himself. Too often, he has refused to take the responsibility for the housekeeping tasks in his institution. As a result, the number

because anemia complicates
so many clinical conditions

TRINSICON

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MAJOR ADVANTAGES: 1. Overcomes excess craving for food. 2. Reduces tissue water retention. 3. Alleviates nervousness and irritability.



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LETTERS

of deans and directors has multiplied, and the professional man has lost effective control.

The problem is how to employ servants without letting them run the house. I think the only answer is for the professional man to show his willingness to exercise responsible authority.

Stephen W. Gray, PH.D.
Decatur, Ga.

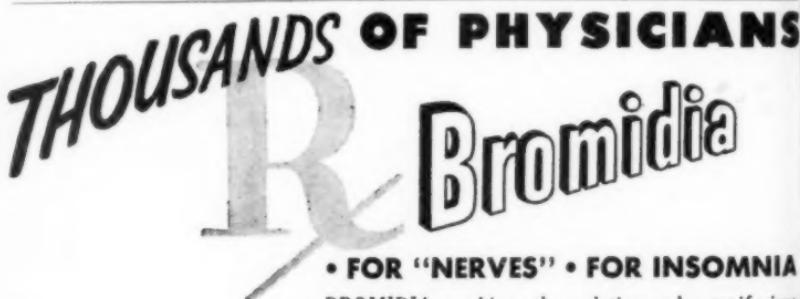
SIRS: I'm one of the hospital supernumeraries your article mentioned. I have the dubious title, "Director of Public Relations."

My hospital has been having a bad time financially. I was added to the staff to promote goodwill—

and thus to get some badly needed donations. But the governing board doesn't realize that the public's unwillingness to lend support indicates there's something basically wrong with the institution . . .

Our administrator governs with an iron hand. He's the only staff member who meets with the board. Every single doctor on the staff complained to me, the first time I met him, that M.D.s are left out of top-echelon planning.

Then I discovered that the hospital's by-laws guarantee the rights of our medical staff! The constitution accords equal recognition to the chief of staff and to the administrator. It calls for a report from



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REED & CARNICK
JERSEY CITY 6, NEW JERSEY

*T.M. Reg.



LETTERS

the staff at meetings of the board.

I pointed these things out to the doctors—and you never saw such backing and filling. One man suggested that I persuade *other* doctors to write to the board, calling their attention to the bylaws.

I've concluded that many physicians don't *want* control. They prefer to complain about not having it. They find a way to blame everything—from bad food to unnecessary operations—on the administrator.

Name Withheld on Request

SIRS: It's no wonder that Dr. A. J. Allenby, author of "Must Staff Meetings Have Captive Audiences?" didn't want to sign his right name. That boy needs protection. If I were a staff member of Dr. Allenby's hospital, I'd try to get him removed to protective custody as a dangerous schizoid.

Here is a man who states that, as an administrator, he's gratified to be in a position where he can make doctors jump when he cracks the whip. As a doctor, though, he grieves over the lowly state to which his staff has been reduced.

... It's obvious that this man has forgotten the ethics he learned in medical school. At the same time, he has absorbed none of the principles of sound hospital management ...

Anthony S. Dickens

Executive Director
Springfield City Hospital
Springfield, Ohio

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Protein Previews



New Study Shows Gelatine

Restores Brittle Fingernails to Normal

Directions for making the Knox Gelatine drink in every package



Brittle, fragile or laminating fingernails are the bane of many a woman's existence. Now, you can promise these patients substantial relief in a large percentage of cases.

In a recent study¹ that confirmed previous work² Knox Gelatine was used to treat 36 women with fragile, brittle, laminating fingernails. Except for three patients who discontinued the therapy, three diabetics, and two women who had congenital deformities, the splitting ceased and all other patients were able to manicure their nails to a full point by the time the study ended.

Optimal dosage proved to be one envelope (7 grams) of Knox Gelatine ad-

ministered daily for three months. Improvement, however, was noted after the first month.

1. Rosenberg, S. and Oster, K. A., "Gelatine in the Treatment of Brittle Nails," *Conn. State Med. J.* 19:171-179, March 1955.
2. Tyson, T. L., *J. Invest. Dermat.* 14:323, May 1950.

Chas. B. Knox Gelatine Company, Inc.
Professional Service Dept. ME-14
Johnstown, N. Y.

Please send me a reprint of the article by Rosenberg and Oster with illustrated color brochure.

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No matter how you measure it, AUREOMYCIN® Chlortetracycline can claim a distinguished record: in terms of published clinical trials—there are more than 8,000; as for actual doses administered—the figure is more than a billion.

But the most significant fact is told by time. For eight years, AUREOMYCIN has been in daily use, repeatedly employed by thousands of physicians throughout the world.

Again and again, it has proved to be a reliable broad-spectrum antibiotic: well-tolerated, prompt in action, effective in controlling many kinds of infection.

A convenient dosage form for every medical requirement.

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Now Available:

AUREOMYCIN SF Capsules, 250 mg.

Chlortetracycline with Stress Formula Vitamins.

For Patients with Prolonged Illness AUREOMYCIN SF combines effective antibiotic action with Stress Formula vitamin supplementation to shorten convalescence and hasten recovery. One capsule, q.i.d., supplies one gram of AUREOMYCIN, and B complex, C and K vitamins in the Stress Formula suggested by the National Research Council. AUREOMYCIN SF Capsules are dry-filled and sealed, contain no oils or paste.

Each capsule contains:

Aureomycin Chlortetracycline	250 mg.
Ascorbic Acid (C)	75 mg.
Thiamine Mononitrate (B ₁)	2.5 mg.
Riboflavin (B ₂)	2.5 mg.
Niacinamide	25 mg.
Pyridoxine (B ₆)	0.5 mg.
Folic Acid	0.375 mg.
Calcium Pantothenate	5 mg.
Vitamin K (Menadione)	0.5 mg.
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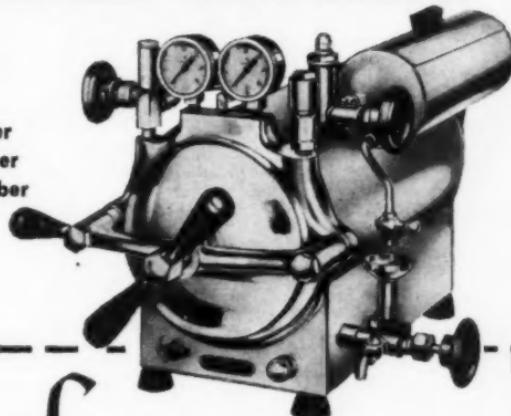


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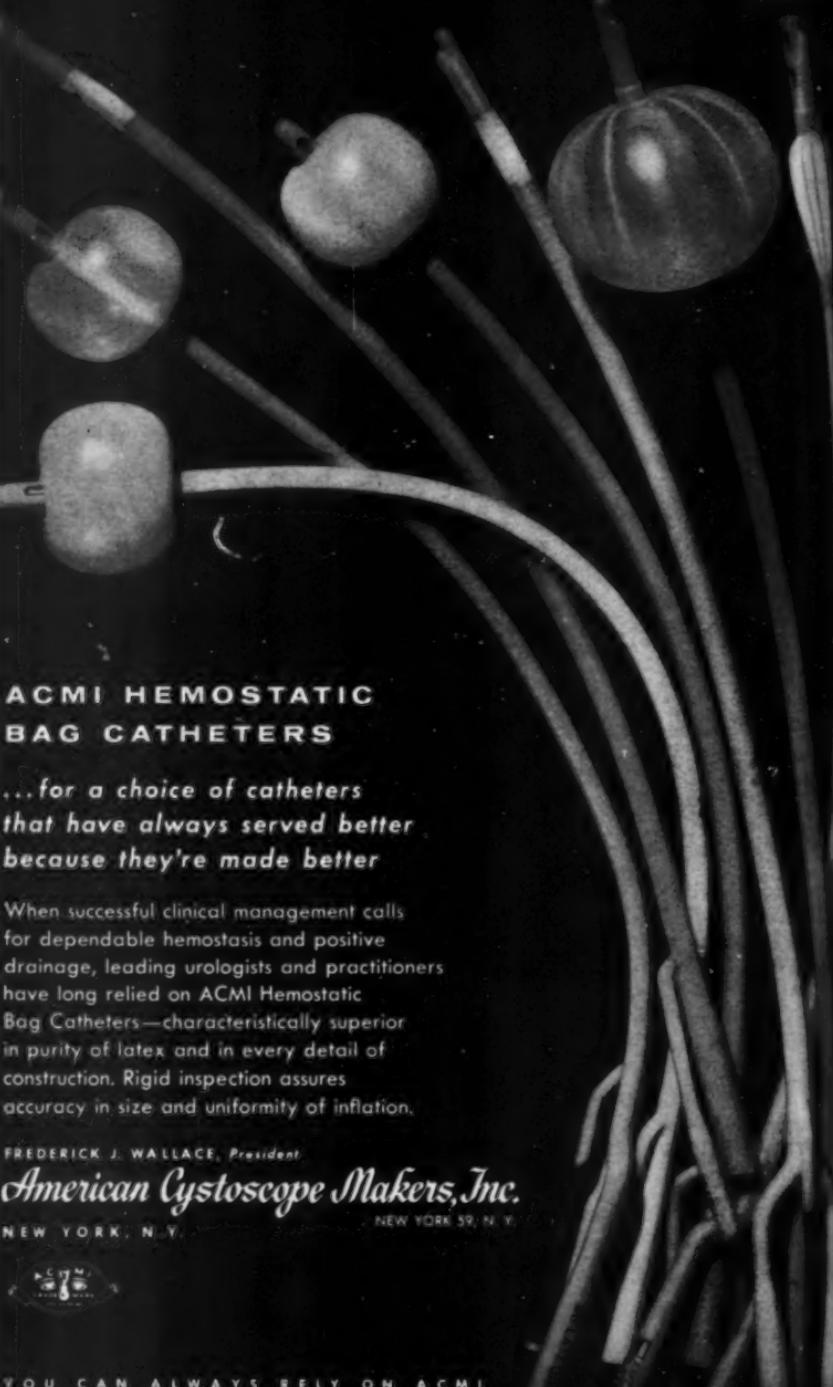
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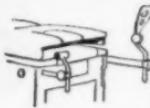
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Table shown is from the handsome Nu-Trend suite. But the brilliant new beauty and efficiency are typical of all Hamilton equipment . . . Fully adjustable Fit-All stirrups, for example, can now be moved in and out of concealment without lifting table's foot end . . . Plastic paper cutter for the clean STER-O-SHEET table covers is now both adjustable and removable.



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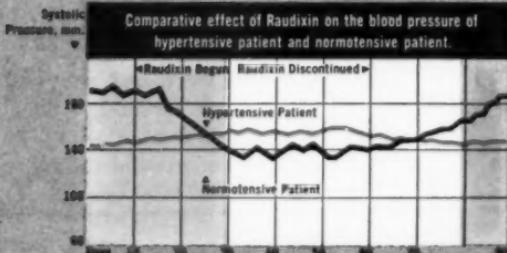
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in anxiety and tension states...

stable ataractic (tranquilizing) effect
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stable hypotensive effect without rapid peaks
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The hypotensive action of Raudixin is selective for the hypertensive state. For this reason, Raudixin does not significantly affect the blood pressure of normotensive patients.

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. . . and HP*ACTHAR Gel should be used routinely to minimize adrenal suppression and atrophy in patients treated with prednisone, prednisolone, hydrocortisone and cortisone.

HP*ACTHAR Gel is the most widely used ACTH preparation

*Highly purified

1. Wolfson, W. Q.: Mississippi Valley M. J. 77: 66, 1955.



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invitation to asthma?

not necessarily . . .

Tedral, taken at the first sign of attack, often forestalls severe symptoms.

relief in minutes . . . Tedral brings symptomatic relief in a matter of minutes. Breathing becomes easier as Tedral relaxes smooth muscle, reduces tissue edema, provides mild sedation.

for 4 full hours . . . Tedral maintains more normal respiration for a sustained period—not just a momentary pause in the attack.

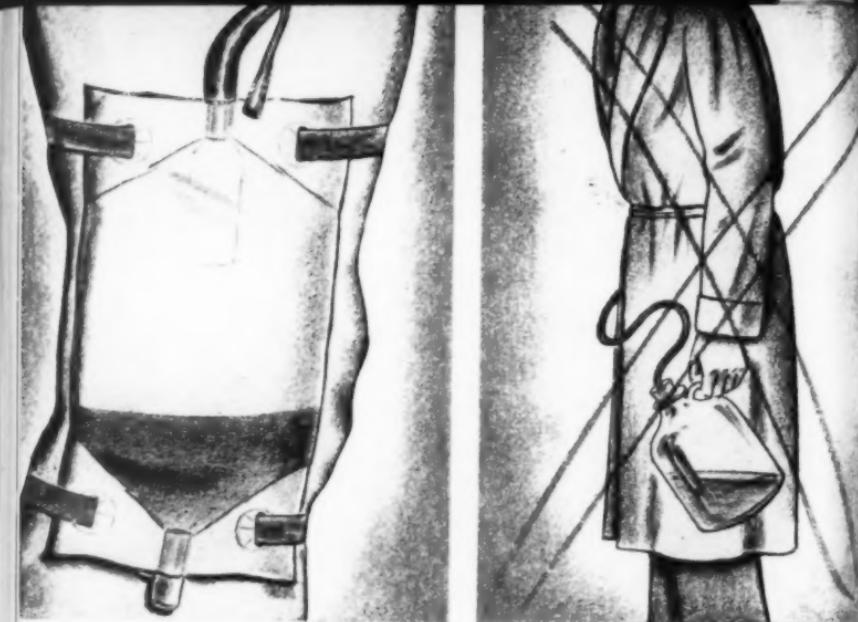
Tedral provides:

Theophylline 2 gr.
Ephedrine HCl $\frac{3}{8}$ gr.
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in boxes of 24, 120 and 1000 tablets

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Comes sterile ready for use, in in-

dividual package. Complete with built-in adapters to fit catheters or tubes.

Saves nurses from disagreeable work of emptying urine receptacles and cleaning and deodorizing bottles, connectors and tubing.

Inexpensive and gladly paid for by patient when charged to account. May be worn home by patient or discarded.

C. R. BARD, INC. SUMMIT, N. J.

new way in x-ray

Is dial-the-part automation
in Picker Century II



simple...
direct...
easy...
no charts...
no calculations
here's all you do...

CHEST
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72"

dial
the body part
on the big selector scale
(inset here is a typical
body-part "station").

set
its thickness
point the needle to the in-
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tient you're x-raying.

take
the radiograph
that's all there is to it:
the-part" automation ta-
easy, gets it right every

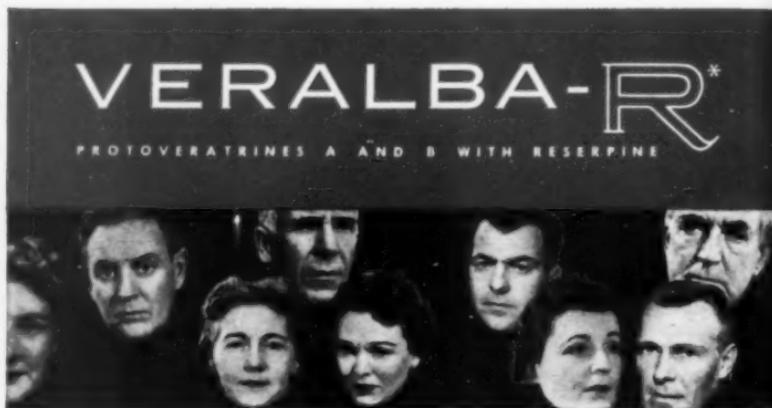
Automatic Century II
fluoroscopic-radiographic x-ray unit

Ask your local Picker representative about the new
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you how modest its cost, what a boon for you it may
prove to be.

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Conservative therapy in hypertension can be made more effective



IN MANY OF YOUR HYPERTENSIVE PATIENTS, conservative treatment with reserpine can be made more effective by placing the patient on safe combination therapy.

EFFECTIVE. When combined with reserpine, the blood pressure lowering effects of protoveratrines A and B can be achieved with smaller dosage, and with marked decrease in annoying side actions.

SAFE. Veralba/R is many physicians' choice of combination therapy. It can be used routinely without causing postural hypotension or impairing the blood supply to the heart, brain and other vital organs. Dosage is simple.



ACCURATE. Veralba/R potency is precisely defined by chemical assay. All active ingredients are in purified, crystalline form.

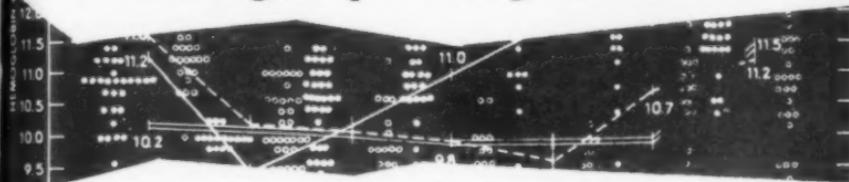
Each Veralba/R tablet contains 0.4 mg. of protoveratrines and 0.08 mg. of reserpine. Bottles of 100 and 1000 scored tablets.

*Trademark

PITMAN-MOORE COMPANY, Division of Allied Laboratories, Inc., Indianapolis 6, Indiana



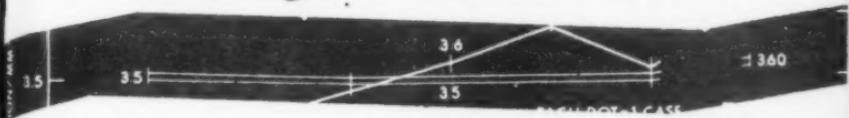
"...in a higher percentage of cases..."



...a greater increase



in hemoglobin concentration...



*...with almost no side reactions."**



mol-iron® tablets

MOLYBDENIZED FERROUS SULFATE
Mol-Iron Liquid Mol-Iron Drops

Forman, J. B.: Anemia of Pregnancy. Connecticut M. J. 14 : 930 (Oct.) 1950.
Extensive bibliography on request.

WHITE LABORATORIES, INC., KENILWORTH, N.J.

Editorials

Hospital staffs have too

many arbitrary rules • How to avoid income-tax errors • A caution against collection stickers • Let's talk about fees • The real question in military medicine

Arbitrary Staff Rules

Last year the A.M.A. Committee on Medical Practices reported finding a wide range of "arbitrary restrictions by hospitals against general practitioners, regardless of their qualifications as individuals." The committee didn't document its finding. But recently one member of the committee did.

He cites, for example, the new system of staff privileges at Georgetown University Hospital in Washington, D.C. Before it went into effect, one G.P. on the staff was a qualified instructor in obstetrics. Now he can't even admit his own OB patients to the hospital.

There's a hospital in Pennsylvania where G.P.s may set fractures under local but not under general anesthesia. Says one staff member: "I'm presumed capable of setting a Colles' fracture as long as I use a local. But if I call for Pentothal to be administered by

the same anesthetist the surgeon uses, then I'm presumed incapable. It doesn't make sense."

In Baltimore's Mercy Hospital, a G.P. who brings his patient to the emergency room can't suture a simple laceration there or even open an abscess . . . In the North Shore Hospital of Manhasset, N.Y., G.P.s aren't allowed to circumcise the babies they've delivered . . . In a Newark, N.J. hospital, G.P.s must request permission from the obstetrical resident to do a simple episiotomy . . . The chief of obstetrics in Passavant Hospital, Pittsburgh, must be telephoned every time a general practitioner there wants to use outlet forceps.

Elsewhere in this issue, an article asks the question: "What Qualifies a Doctor to Do Surgery?" It seems to us that any attempt to answer this question in general terms results in arbitrary staff rules like the ones reported here.

Only when it's answered in terms of the *specific staff member*



Which child is being treated with old-fashioned nose drops? Which with 'VASOCORT'?

That's easy. The youngster on the right is being treated with 'Vasocort', the new concept of intranasal therapy.

Until the introduction of 'Vasocort', reduction of intranasal congestion and inflammation was usually achieved topically by vasoconstriction with potent pressor drugs—which all too often produce burning, stinging and rebound turgescence. These side effects are frequently even more unpleasant than the intranasal disorder itself.

'Vasocort', in contrast, owes much of its success in the treatment of children to its almost 100% lack of undesirable side effects. That is because of the extremely low concentrations of its anti-inflammatory agent (hydrocortisone) and of its *two* decongestants (phenylephrine and Paredrine*).

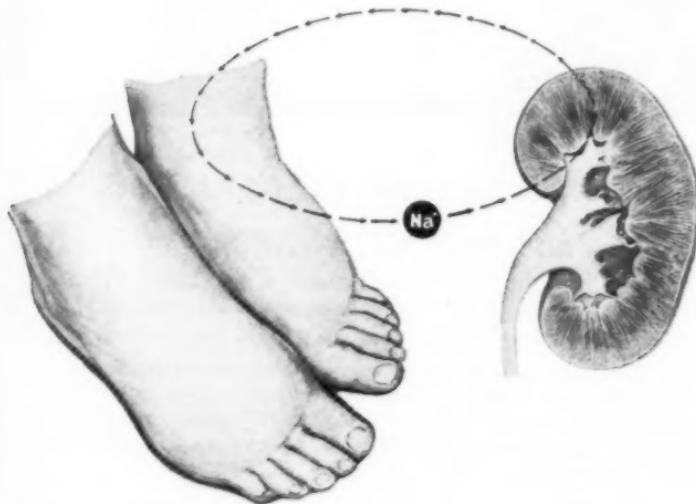
'Vasocort', which is rapidly replacing the traditional high-potency vasoconstrictor, has been administered over an extended period of time to children ranging from 9 months to 11 years. Results have been uniformly good.

VASOCORT*
(Hydrocortisone
and 2 Decongestants)

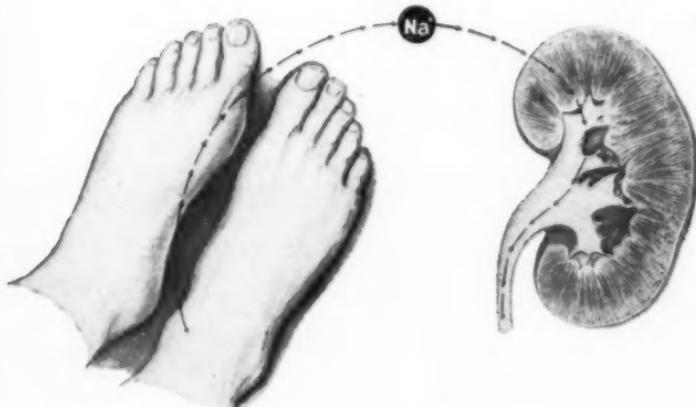
*T.M., Reg. U.S. Pat. Off.

Smith, Kline & French
Laboratories, Philadelphia 1

New Orally Effective Diuretifo



WITHOUT MICTINE—Prior to diuretic therapy excessive sodium and water are characteristically retained in the edematous patient.



WITH MICTINE—Inhibition of the reabsorption of sodium ion leads to an increased excretion of sodium ion, water and chloride.

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*Tradem

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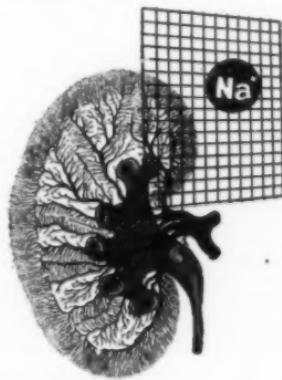
XUM

MICTINE® — ORAL NON-MERCURIAL DIURETIC

etifor Congestive Edema

Best results are obtained when Mictine is administered with meals on an interrupted dosage schedule.

An effective diuretic has been described as one which causes excretion of water, sodium and chloride in amounts sufficient to reduce the edema but not to result in the syndrome of salt depletion.



Mictine (brand of aminometradine), end result of many years of Searle Research, introduces to clinical practice an *improved* diuretic which not only meets the standard qualifications but has these seven additional advantages:

Mictine is orally effective; it is not a mercurial; it has no known contraindications; it does not upset the acid-base balance; it exerts no significant influence on electrolyte balance; it may be given in the presence

*Trademark of G. D. Searle & Co.

Clinical trial packages sufficient for three patients are available on request to . . .

SEARLE

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EDITORIALS

—his training, experience, and talent—will such unfair restrictions be reduced.

Income-Tax Errors

According to a former high official of the Internal Revenue Service, three-quarters of all physicians with taxable incomes above \$10,000 make mistakes on their income-tax returns. And most of these mistakes favor the taxpayer.

This phenomenon is not limited to the medical profession. Indeed, the man making the estimate based it on a broad sampling of returns from people in all walks of life—physicians included. He sees no

reason to believe that physicians are either more or less error-prone than the entire group.

But if physicians are only normally error-prone, they suffer more because of it. The notion has got around that they're the best targets for tax audits—that every dollar spent on such audits will produce maximum income for the Government. Each mistake discovered on a doctor's return strengthens this notion among T-men.

How can the profession get itself off this spot? Dr. H. Sheridan Baketel, this magazine's late editor-in-chief, once offered this timeless capsule of tax advice:

1. *We can keep our own records*

endorsed by 15 years of
physicians' and patients' use...

color-calibrated
CLINITEST[®]
BRAND

the urine-sugar test with the Laboratory-Controlled color scale



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Relieves
emotional tension
while restoring
hormonal balance

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"Tylandril" offers you a new, integrated therapeutic approach for your menopausal patients. The androgen-estrogen combination effectively restores hormonal balance. Its synergistic action reduces dosage requirements and minimizes such side-effects as withdrawal bleeding, breast tenderness, and nausea.

"Sandril" (Reserpine, Lilly) has been added to the formula to combat the psychologic stress of the menopause. It induces a calming effect and facilitates emotional adjustment of your climacteric patient.

*Now available in bottles of 100
at pharmacies everywhere.*

each scored Tablet "Tylandril" provides:

Diethylstilbestrol	0.25 mg.
Methyltestosterone	5 mg.
"Sandril" (Reserpine, Lilly)	0.1 mg.

DOSAGE: Initially, 1 to 2 tablets daily for one or two weeks. Maintenance, usually 1/2 to 1 tablet daily.

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MEDICAL ECONOMICS • MARCH 1956

83

In 30 minutes—
antibacterial
action begins

In 24 hours—
turbid urine
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"... it appears that Furadantin is
one of the most effective single agents
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BRAND OF NITROFURANTOIN

IN
URINARY
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INFECTIONS

- specific affinity for the urinary tract produces high antibacterial concentrations in urine in minutes—continuing for hours
- hundreds of thousands of patients treated safely and effectively
- rapidly effective against a wide range of gram-positive and gram-negative bacteria, including many strains of *Proteus* and *Pseudomonas* species and organisms resistant to other agents
- excellent tolerance—nontoxic to kidneys, liver and blood-forming organs
- no cases of monilial superinfection ever reported

SUPPLIED: Tablets, 50 and 100 mg. bottles of 25 and 100. Oral Suspension, 5 mg. per cc. bottle of 118 cc.

*Breskey, R. S.; Holt, S. H., and Siegel, D.: J. Michigan M. Soc. 54:986, 1955.

EATON LABORATORIES, Norwalk, N. Y.



NITROFURANS a new class of antimicrobials
neither antibiotics nor sulfa

above suspicion—if necessary, hiring an accountant to whip them into shape. Complete records generally speak for themselves—which is better than having to explain them in person to a tax investigator.

2. We can help spike the notion that doctors needn't be too careful in accounting for cash receipts. Whether or not this was ever true, it isn't today. Cross-checks being used in selected cases include a study of bank records; a review of expensive trips or purchases; and a comparison of reported income with increases in net worth.

3. We can help publicize the penalties that are being handed out. Only a fool would knowingly

risk such things as prison, loss of license, total destruction of a practice. And medicine has no room for fools.

Collection Caution

Ever used a collection sticker? It's a gummed reminder notice, something like a large postage stamp, that can be attached to the statements you send slow-paying patients. It's an occasionally effective device that, in our opinion, should be used with caution, if at all.

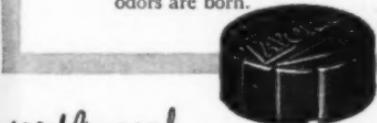
We've been looking over the collection stickers that doctors in some areas are now being urged to buy. "These colorful, attention-

WHAT IT IS...

Lavoris is a safe, efficient, delightfully refreshing mouthwash and gargle—designed to help maintain the mouth and throat tissues in a clean, wholesome and more resistant condition.

WHAT IT DOES...

One mouthful of Lavoris vigorously swished and gargled breaks up, flushes out, REMOVES the mucus coating or film, the "bed" where germs thrive and where most mouth odors are born.

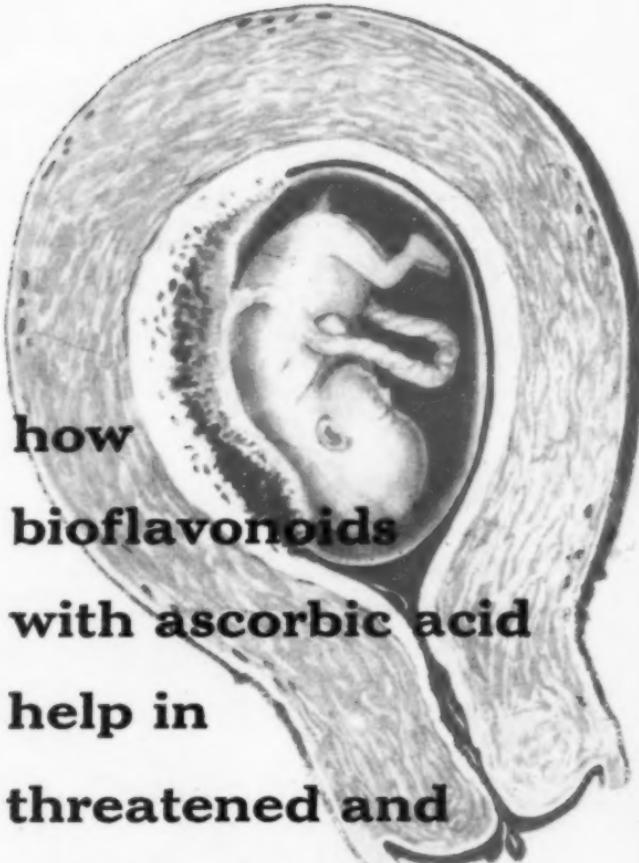


sparkling red

The mouthwash that tastes good and does good

*Pleasing, spicy taste
makes it
easy to use.*





**how
bioflavonoids
with ascorbic acid
help in
threatened and
habitual abortion...**

Frequent nosebleeds, gum bleeding and easy bruising were observed in a high percentage of women who had repeated abortions, according to one study.¹

Another investigator² reported abnormal capillary fragility in 80% of habitual aborters.

C.V.P. helps to diminish abnormal capillary permeability and fragility by acting to maintain the integrity of the "cement" substance of capillary walls. Thus, C.V.P. may be a helpful adjunct in the management of threatened and habitual abortion.

C.V.P. provides the capillary-protectant factors of whole citrus bioflavonoid compound (sometimes referred to as "vitamin P complex"), combined with ascorbic acid.

C.V.P. is water-soluble and believed to be more readily absorbed than relatively insoluble rutin.



Each C.V.P. capsule or teaspoonful (5 cc.)
of syrup provides:

Citrus Flavonoid Compound . . . 100 mg.
Ascorbic Acid (vitamin C) . . . 100 mg.

rationale: The correction of abnormal capillary fragility in habitual aborters supposedly "decreases the possibility of retroplacental hemorrhage, or possibly enhances the efficacy of established therapeutic regimens by modifying capillary permeability and vascular disturbances throughout the body, whether they be in the skin, liver or the placenta."²

Bottles of 50, 100, 500 and 1000 capsules; 4 oz., 16 oz. and gallon syrup.

1. Science News Letter, March 1954
2. Greenblatt, R. B.: Obstet. & Gyn. 2:530, 1953

samples and literature from **U. S. vitamin corporation**
(Arlington-Funk Laboratories, division)
250 East 43rd Street, New York 17, N.Y.

EDITORIALS

getting messages," the manufacturer claims, "flag the eye of the debtor, jog him into prompt payment, yet keep his goodwill."

We wonder.

Take the folksy model (in bright pink) that reads: "We were mighty happy to honor your credit. Won't you return this trust by honoring our statement?" Or the sad appeal in scarlet: "We pay our bills on time only because folks pay us. Right now . . . we need your help." Or the delicate hint in black and yellow, "PROMPT PAYMENT will enable us to serve you better."

Far from producing results, commercial collection devices often prove a boomerang for the doctor. And the most commercial of all such devices is apt to be the collection sticker. Most of the printed messages we've seen warrant this warning: Caution: Handle with care!

Let's Talk Fees

More than 22,000 physicians have publicly declared themselves ready to discuss fees with patients before treatment. These are the men who display the A.M.A.'s plaque to that effect in their waiting rooms.

But what of the 125,000 or so other private practitioners in the country? Apparently many of them still prefer to mention fees only when it's time to send out bills. And apparently at least some of these men are making a serious

mistake. Witness this complaint from a prominent Easterner:

"Why is it," this man asks, "that a doctor so often evades you when you try to discuss fees?"

"Let's worry about that later," the doctor says.

"Maybe it's altruism—and maybe it's just that he knows the cost is going to be high and he doesn't have the guts to say so to your face. He waits until the services have already been rendered. Then he lets you have the bad news by mail."

"In my opinion, the one sure way to make a patient worry about costs is to tell him *not* to worry about them. It's like taking a taxi that doesn't have a meter."

"Drive me to Yankee Stadium," you say. And before the driver starts, you ask, 'About how much will the fare be?'

"Oh, don't worry about that," answers the cabbie. "Let's get you to the ball park first."

"Would *you* worry? Me, I wouldn't even take the ride. Not with *that* driver."

Military Question

Whenever the staff-room conversation gets around to military medicine, someone is quite likely to say: "The Doctor Draft Act is discriminatory, unfair, and unconstitutional. Everyone admits it. Why doesn't the A.M.A. seek a test case in court?"

[MORE ▶]

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MYCOSTATIN

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the first safe
antifungal antibiotic



VAGINAL TABLETS

highly effective in vaginal moniliasis

Each vaginal tablet contains 100,000 units of Mycostatin and 0.95 Gm. of lactose. Packages of 15.



ointment

*highly effective in monilial infections
of the skin*

100,000 units of Mycostatin per gram. 30 Gm. tubes.



ORAL TABLETS

*highly effective in intestinal
moniliasis; sometimes effective in
generalized (systemic) moniliasis*

Each tablet contains 500,000 units of Mycostatin.
Bottles of 12 and 100.

Also available:

broad spectrum antibacterial therapy
plus antifungal prophylaxis

MYSTECLIN CAPSULES

250 mg. Steclin (Squibb Tetracycline) Hydrochloride
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When you think ra

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Dramcillin

Everyone thinks it's a "treat"

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oral penicillin...

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in liquid oral penicillin with real "taste appeal"

potassium penicillin G—the ideal oral penicillin salt

higher initial peaks and more prolonged blood levels

250,000 units of buffered potassium penicillin G solution per teaspoonful
fully effective in 3 to 4 teaspoonful doses daily—no disturbance of sleep
or feeding schedules

100,000 units of buffered potassium penicillin G solution per teaspoonful
delicious flavor, particularly suitable for the younger child
... both potencies in 60 cc. bottles—

available—

penicillin-300 Suspension—a ready to use, stable suspension providing 300,000
units of potassium penicillin G per teaspoonful

EDITORIALS

Such men don't realize that there *has* been a test case. This case, according to the A.M.A. Law Department, just about settled the issue. Here's what happened:

Dr. William R. Bertelsen of Neponset, Ill., was called up for active duty in 1953. He declined a commission as a medical officer and was then drafted into the Army as a private. Immediately he moved for his release on the ground that he'd been drafted under an unconstitutional law.

When a Federal district court ruled against him, Dr. Bertelsen appealed to the Fifth Circuit Court of Appeals. Again the ruling went against him. "Whether [the Doc-

tor Draft] is wise or unwise, fair or unfair, necessary or unnecessary is for legislative not judicial determination," said the Court. "It is for Congress to say . . . how [members of the armed forces] shall be selected." On appeal, the Supreme Court refused to review the case.

Thus the military question we should be asking ourselves is not whether the Doctor Draft is legal. Instead, it's this: "What incentives will attract enough career medical officers to make the Doctor Draft unnecessary after June, 1957?"

With about half of all regular medical-officer billets unfilled, this question calls for the best answers our entire profession can provide.

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AMINET®
(Aminophylline with Pentobarbital)
Suppositories

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exclusive
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of
"crown jewels" of
salicylate therapy

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FOR PATIENTS
with gouty arthritis

NEOCYCLATE WITH COLCHICINE

TRADEMARK

Unites the specific value of colchicine for diagnosis and treatment of gout with the dual action of salicylate as analgesic and uricosuric agent. NEOCYCLATE with COLCHICINE is one of the "crown jewels" of Central's family of potentiated salicylate products.

Each enteric-coated tablet contains:
Sodium Salicylate . 0.25 Gm. (4 gr.)
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Supplied: Bottles of 200, 500 and 1000 yellow tablets.

Literature on Request



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gastroduodenal and biliary pain \rightleftharpoons spasm

Prescribe the
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Dactil®

Relieves pain \rightleftharpoons spasm
usually in 10 minutes.
Does not interfere with digestive
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Normalizes motility and gastric
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generalized
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rapid, prolonged
relief throughout
the g.i. tract

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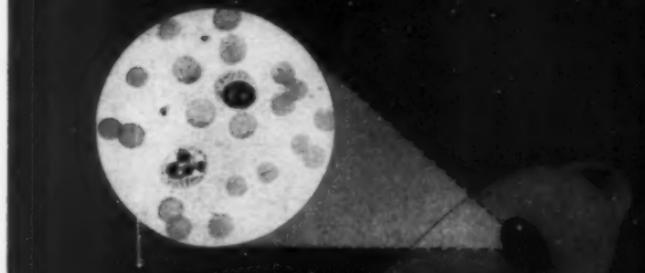
paired piperidol action

One TRIDAL tablet two or three times a day and at bedtime is best for patients needing comprehensive control. The local action of DACTIL relieves pain and spasm almost immediately. PIPTAL enhances this relief and prolongs normalization of motility and secretion. Each TRIDAL tablet contains 50 mg. of Dactil and 5 mg. of Piptal. Unless rapidly swallowed with water, TRIDAL will produce some lingual anesthesia. Bottles of 50.

Patients for whom you prescribe TRIDAL, DACTIL or PIPTAL remain singularly free of antispasmodic or anticholinergic side effects—urinary retention, constipation, dry mouth, blurred vision.

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response...use the
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ARMATRINSIC

- with new ferrous betaine hydrochloride...releases hydrochloric acid, important for proper iron absorption.
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AND WHEN A LIQUID HEMATINIC IS PREFERRED

PREScribe **ARMATINIC® Liquid**

FOR A FAST START AND VIGOROUS IMPROVEMENT

Bottles of 8 and 16 fl.oz.



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Just 1 Armatinic capsule b.i.d. supplies:	
Vitamin B ₁₂ with Intrinsic factor Concentrate*.	1 U.S.P. Unit (Oral)
Liver Fraction 2 N.F. with Duodenum (Containing Intrinsic factor)... 100 mg.	
Vitamin B ₁₂ Activity concentrate 10 mcg.	
Ferrous Betainate HCl equivalent to:	
100 mg. of Elemental Iron	
18 cc. of N/10 HCl..... 666 mg.	
Folic acid..... 1.4 mg.	
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Cobalt Chloride..... 30 mg.	
Molybdenum..... 1.5 mg.	
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Zinc..... 0.50 mg.	

*Unitage established before compounding

Adults: 2 or 3 capsules daily with meals

Bottles of 50 capsules (small, attractive, odorless)

G.P. vs. surgeon:

What Qualifies a Doctor To Do Surgery?

At a recent A.M.A.-sponsored symposium, a leading general practitioner said:

¶ "When [a G.P.] must call a surgeon to suture a one-inch laceration in the emergency room or tape a chest for a fractured rib . . . then the whole unsavory problem of arbitrary restriction of the generalist is carried to the point of absurdity . . ."

¶ "If a man has done fifty appendixes . . . if it's felt that he's capable of handling anything that comes up in that operation—then he ought to be *allowed* to handle it . . ."

At the same symposium, a leading surgeon said:

¶ "... I wouldn't want to send any member of my family to him for an operation. If there is any question in our minds about surgical privileges, I think that is a good test . . ."

¶ Board certification "leaves very much to be desired . . . We all know that many certified men should not have been given the recognition of the Board . . . It's not an ideal method. It's simply the best we have been able to come up with . . ."

The G.P. quoted is John S. DeTar of Milan, Mich. The surgeon is Leland S. McKittrick of Boston. Their further exchanges on the subject of surgical privileges follow in condensed form. [MORE►]

The Surgeon Speaks



DR. McKITTRICK: I am what is known in this part of the country [Massachusetts] as a general surgeon. My formal training consisted of fourteen months'

internship. It should have been twenty months, but the first World War was on and I got off.

After the war I became associated with one of the older surgeons in Boston, Dr. Daniel F. Jones, now deceased. With him I learned most of the basic principles of surgery.

I had done practically no surgery before my association with him. Certainly I had done none in my fourteen months' training in the hospital, and I did none with him for the first few years.

Dr. Jones had a large surgi-

The G.P. Speaks



DR. DETAR: I believe that the modern emphasis on specialism has led to a plethora of specialists, particularly general surgeons. I believe that general practice is in danger of extinc-

tion, slow death by strangulation.

Do the American people want general practice preserved? The answer to that question came a year ago when there appeared in the Reader's Digest a three-page article entitled, "Family Doctor, 1955 Model." That article described the modern generalist as a family physician who maintained pace with modern medicine through post-graduate education and who retained membership in the American Academy of General Practice only by proof of such studies.

WHAT QUALIFIES A DOCTOR?

cal practice and I assisted him with all his operations. Then I became responsible for the care of certain patients who were in the surgical wards of Massachusetts General Hospital. Eventually I and my associates did most of the operations. So my technical training came at Massachusetts General.

But the mentoring, if you want to call it such, came primarily from my association with Dr. Jones. That is quite in contrast to the situation at the present time.

What is our objective today in training a surgeon? What procedures should a young man be able to carry out at the end of his training?

He should be able to operate in the abdomen or the chest, and he should feel as much at home in one as the other. He should feel completely competent to handle whatever emergency may arise in whatever body cavity he is in, unless he is there under unusual circumstances.

That is a big order. But if he

The magazine had hardly hit the newsstands when an amazing thing took place. Seventy thousand letters from all corners of the United States poured into Academy headquarters. And 90 per cent of them asked for a list of doctors filling this description.

One letter from Memphis said: "We should like to have a general practitioner whose major interest is internal medicine, who does surgery in uncomplicated cases, yet who wouldn't hesitate to call a specialist when he deemed it necessary." That

is an appropriate appreciation of the teamwork needed between the specialist and the generalist.

Seventy thousand letters from one little article, from people who want a family physician and haven't been able to find one! They are still coming at the rate of a hundred or more per day.

Now, you may be saying: "This is a matter of medical service and professional distribution." I believe it is not.

The deficiencies in medical care today are the direct result

The Surgeon Speaks

is unable to do that, I wouldn't want to send any member of my family to him for an operation. If there is any question in our minds about surgical privileges, I think that is a good test.

Today the length of time a surgeon spends in graduate training is usually five years—one year of internship and four years of residency. He takes on increasing responsibili-

ties, ending up with the total care of patients under his supervision. When a young man finishes this training program, he is able to do any type of operation. Most of the young men I am talking about can do any of the operations I can do. And many do them better technically.

What are the problems in teaching a surgeon?

Many people say all a surgeon does is cut. But I think it is our responsibility to decide

The G.P. Speaks

of the trend the medical profession has allowed to develop in medical schools and in graduate education. It is just this simple: We are educating too many specialists and too few properly prepared generalists.

There is almost universal agreement that two years of graduate training should constitute the minimum for the generalist. Yet where is the young graduate to find such training? Only 131 hospitals in the country offer general practice residencies. And of the 500 posi-

tions offered, only 56 per cent are filled.

We are today training 17,600 residents in the specialties and only 302 in general practice residencies. Why? What drives interne after interne into special training against his previously expressed desire?

One reason is the arbitrary limitation of the general practitioner in his hospital privileges—class legislation, if you will.

When a generalist is forced by hospital rule to call in a urologist to perform a circumcision . . .

WHAT QUALIFIES A DOCTOR?

whether or not an operation should be done. The diagnostic work or its evaluation is the responsibility of the surgeon. Therefore, the younger man in surgery must be trained in preoperative as well as postoperative care. He must have a knowledge of the fluid balances associated with the patient. He must be acquainted with the physiological and emotional problems of the patient about to undergo surgery.

Then we have to teach them

how to do the technical side of the operation. Finally, with critically ill patients, they must know *when* to do it. The right operation at the right time by somebody not a very good technician is safer than a finer operation at the wrong time.

Those are the problems. How difficult are they to teach? Well, it is not difficult to teach preoperative or postoperative care. Technique is not hard to teach; in fact, it is the easiest thing you have to teach. But how

When he is confined to a single department such as medicine, to the exclusion of pediatrics, obstetrics, and surgery—regardless of his demonstrated capacity . . .

When he must call a surgeon to suture a one-inch laceration in the emergency room or tape a chest for a fractured rib . . .

When he cannot do an episiotomy or apply low forceps without consultation . . .

Then the whole unsavory problem of arbitrary restriction of the generalist is carried to the point of absurdity.

The trouble begins in the

medical schools. I would like to read a letter from a senior at Duke University Medical School. He says:

"Here there is no subject matter in general practice. There's no family to visit and follow through our medical teachings, as some other medical schools provide. There's little attempt to look at the patient as a whole."

"If it's an itch, send the patient to the allergy clinic; if it's an itch with a rash, to the dermatology clinic. If she's bleeding, Gyn. gets her. If she's not bleeding, send her to the en-

The Surgeon Speaks

is unable to do that, I wouldn't want to send any member of my family to him for an operation. If there is any question in our minds about surgical privileges, I think that is a good test.

Today the length of time a surgeon spends in graduate training is usually five years—one year of internship and four years of residency. He takes on increasing responsibili-

ties, ending up with the total care of patients under his supervision. When a young man finishes this training program, he is able to do any type of operation. Most of the young men I am talking about can do any of the operations I can do. And many do them better technically.

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The G.P. Speaks

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The Surgeon Speaks

do you teach young men surgical judgment?

In a sense, you can't teach them surgical judgment. This must come from having total responsibility for patients. It must be learned from having experience under the tutelage of an older and more experienced surgeon. It must come from recognizing and understanding the mistakes of others.

I feel there is no value to the

idea of learning by trial and error. Surgeons should learn by the knowledge of their superiors and by a certain amount of trying. But if a young man on my service were to make the same mistakes I made ten or fifteen years ago, he should be ashamed of me and I should be ashamed of him. It is not good teaching if that happens.

I want to finish up with a comparison:

I learned surgery from an experienced preceptor. I also

The G.P. Speaks

docrine clinic. If it's a joint ache, then the orthopods and the arthritis clinic will fight over it. And so it goes."

The change of emphasis here must be in the direction of providing increased opportunity for the medical student to experience general practice. Such programs are now in force and highly successful at the universities of Tennessee, Kansas, Wisconsin, Mississippi, Colorado, Arkansas, Texas, and at Ohio State, Cornell, Yale, and elsewhere.

What about general practice residencies? The crying need here is for more high-quality, two-year programs sponsored by medical schools—not just eight of them, as at present, but all of them. I point out, too, that if the specialty boards altered their requirements to grant credit for one year in an approved general practice residency, many young men would enter general practice at the conclusion of that period.

But even if these pressing problems of education for general practice could be solved right here, it is doubtful that a

WHAT QUALIFIES A DOCTOR?

went down to the hospital and learned there. Out of that combination I got enough income to live on and later to get married on.

At the present time these boys have a very superior program. They spend five years doing exactly the same things I did. They assist in the wards at Massachusetts General. Then they go back in the wards and do 80 or 90 per cent of all the surgery done there. And what do they get? A little something

to eat and not much more. They are doing it at a tremendous financial sacrifice.

I believe the method of training is sound. I believe it is the only method by which we can train men and turn them loose on the public to engage in surgery. But the \$64,000 question is:

How are you going to maintain this method, if it is correct, and how are you going to pay a living wage to those who carry it out? [MORE▶

dent would be made in the total problem. That's because of the generalists' hospital problems. I refer to the arbitrary restriction of privileges—restrictions that are widespread and growing.

The American Medical Association took dramatic action on this problem recently in these words:

"Resolved, that the representatives of the American Medical Association on the Joint Commission on Accreditation of Hospitals be *instructed* to stimulate action by that body leading to the warning, provisional

accreditation, or removal of accreditation of community or general hospitals which exclude or arbitrarily restrict hospital privileges for generalists as a class, regardless of their individual . . . competence . . ."

This action by the A.M.A. gives renewed hope that the former policy of lip service to the generalist as the backbone of medicine has changed to a dynamic policy. General practitioners must be accorded the privilege of rendering service to their patients in hospitals which the people have built for that purpose. [MORE▶

C.P. vs. Surgeon

DR. DETAR: Dr. McKittrick, do you believe that board certification is the ideal method of determining the capacity of a surgeon? Or do you believe a man can be evaluated best by his confreres on the hospital staff—the men who see him work from day to day?

DR. MCKITTRICK: Attempting to evaluate capacity by the Board leaves very much to be desired. No member of the Board of Surgery, I am sure, would claim we have a completely satisfactory method of evaluating these men. That is why we keep changing the thing. There was a time when every man certified by the Board of Surgery had some recognized surgeon in the community who watched him work, watched him operate.

So to your first question I would say, "No, it's not an ideal method. It's simply the best we have been able to come up with at the present time."

Now, the second question: Should a man be certified on the judgment of his confreres?

I would be compelled to say in answer to that: "Who are his confreres and who is really going to respect their decisions?"

I would expect in many institutions—particularly in the smaller institutions—a man might be judged not on his ability to render good service to the community, but on other factors.

I may be tarred and feathered for that statement. But I have lived too long and practiced medicine too long not to know there are influences which affect such decisions— influences which are not present in the Board of Surgery.

There is no really good way of certifying large groups of men and knowing that you are coming out with the right answer. We all know that many certified men should not have been given the recognition of the Board. I am just as sure we have noncertified men who would be good, safe, and sound surgeons.

I would like to ask Dr. DeTar one thing: What would a two-

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year rotating program in general practice qualify a man to do in surgery?

DR. DETAR: Circumcisions! ... I think that depends on the type of training, Dr. McKittrick. The two-year rotating program at the University of Michigan consists of six months in the University Hospital and six months outside in a small hospital; then two months in pediatrics, two in obstetrics, and two in neuropsychiatry. The last six months are spent in medicine and surgery. That obviously is not complete surgical training.

DR. McKITTRICK: Do you think there might be any differences in the privileges allowed—and I am talking only about surgical privileges, because that is where the bone of contention really is, isn't it? . . .

DR. DETAR: I think that is the largest question, yes.

DR. McKITTRICK: ... Do you think there might be a difference in the privileges permitted the general practitioner who lives in a small community—I might say the Monadnock region in New Hampshire, where we have a seventy-five-bed hospital—and the privileges permitted a general practitioner if he

were put on the staff of a large metropolitan hospital like New England Deaconess Hospital?

DR. DETAR: Dr. McKittrick, I certainly agree with you that no man should attempt to perform any surgical procedure which he is not trained and experienced to do. I live in a community of 3,000 people and I don't do any surgery. All I do is tonsils; but that isn't really surgery.

I don't do any surgery because I wasn't trained to do it. And I live not far from the University of Michigan, where there is the finest surgery available.

I wouldn't argue that any general practitioner should practice in the surgical department when he is not qualified to do it. But I believe you are safe in accepting the judgment of the men in the hospitals.

Frankly, I have seen Board men whose privileges should be removed. It is handled better on a local level.

DR. McKITTRICK: Let's pinpoint this. Possibly general men should be given privileges on a staff doing appendectomies, gall bladders, but not special operations.

[MORE ON 300]

You Get the Damndes

Let

All sorts of people write to doctors: the sane and the insane, the sexed and the oversexed, the sick and the blatantly well.

Some physicians save letters from their more unusual patients. Not long ago, Author Juliet Lowell collected about 200 of these unintentionally funny letters in a new book ("Dear Doctor," copyright 1955, by Juliet Lowell. Published by M.S. Mill Co., Inc. Distributed by William Morrow & Co., Inc.).

Here, with special MEDICAL ECONOMICS art by Al Kaufman, is a selection of the best.

Dr. Allan M. Ross
Darien, Conn.

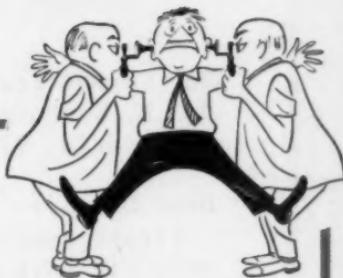
Dear Dr. Ross:

My husband say if baby dont look like him he kill us. What cud I take to be sure it come out o.k.?

Mrs. Imogene D

P.S. The Pa he dont look like my husband.

les
Letters!



Grace & Harper Hospital
Detroit, Michigan

Gentlemen:

Received your letter saying that you cannot put me on the staff as you already have an otologist.

It so happens that you have 2 proctologists on your staff. Since every one has 2 ears and only one rectum why should there be 2 proctologists to one otologist?

Emil Amberg, M.D.

Editor's Note: On the strength of this letter Dr. Amberg received the appointment. [MORE▶

YOU GET THE DAMNDEST LETTERS!



Dr. Carson Lee Fifer
411 N. Washington Str.
Alexandria, Virginia

Dear Doctor:

Please give my husband pills to cut down his love making urge. I got no time to clean the house any more and the bed is falling apart.

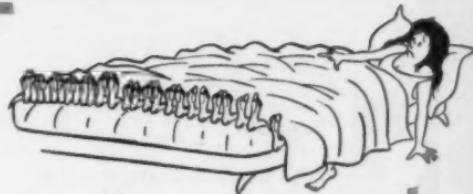
Gracie H _____

Dr. Austin H. Wood
829 Park Ave.
Baltimore, Md.

Dear Doctor Wood:

What would you suggest? I like everything about marriage except—I mean I want to get married without.

Mary Alice W _____



Dr. Tatiana G. Herzfeld
375-76th St.
Brooklyn 9, N.Y.

Dear Doctor Herzfeld:

I have one superstition. I don't like
to sleep 13 in a bed.
Is this a sign of some complex?

Imogene R _____

Dr. Joseph Hodas
205 East 61st St.
New York City

Dear Dr. Hodas:

You told me not to worry about my son
wetting his bed at night and it's per-
fectly normal. Well, I don't think it's
normal and neither does his wife.

Mrs. Olivia J. _____

YOU GET THE DAMNDEST LETTERS!



**Dr. Doris Rappaport
1363 Sussex Rd.
West Englewood, N.J.**

Dear Dr. Rappaport:

I was just thinking. Why did you give me the rabbit test today. You should have given my husband the rabbit test. That's the way he acts.

Mrs. Jack W _____

**Dr. William F. Rienhoff, Jr.
Johns Hopkins Hospital
Baltimore, Md.**

Dear Dr. Rienhoff:

After all you did for me I just got pregnant.

**Thank you
Winnie F _____**

Dr. William M. Hitzig
787 Park Ave.
New York City



Dear Dr. Hitzig:

I received your psychoanalysis report on my wife telling me that her trouble is she has a dual personality. I know this, and my trouble is that I don't like either one of them.

Maurie W _____

Dr. Hugh Bailey
1626 Kanawha, N.E.
Charleston, W. Va.

Dear Doctor Bailey:

I have a daughter 21 who doesn't. Should she?

Mrs. Allan Y _____

A short-term trust may enable you to

Cut \$500 From Your Tax Bill

By T. Kenneth Callister, M.D.

A few doctors I know will have at least one pleasure when April 15 rolls around: They'll be saving about \$500 that would otherwise have gone to Uncle Sam.

How are they doing it? By taking advantage of one of the biggest, least publicized tax breaks written into the 1954 Internal Revenue Code: the liberal rules governing the establishment of short-term trusts.

Don't let the word "trust" scare you. *Short-term* trusts are like miniature golf courses: They're mostly for laymen, not for pros. Of course, it's necessary to have a professional explain the finer points to you before you start playing the game for money. But the basic rules are simple:

You put some income-producing property into a trust that will have a life of at least ten years. And you specify that the income realized from the property during that period will either be paid out to the beneficiary—your minor son, say—or accumulated by the trust for him to use later.

THE AUTHOR was a professional securities analyst for many years before becoming a physician.

Until the ten years are up, you can't touch the principal. But it reverts to you *in full* at the end of the specified period. Meanwhile, you pay no taxes on the income it produces. Instead, such income is taxable either to the beneficiary (if the money's paid to him) or to the trust (if it accumulates the money).

Any decision as to whether the trust should accumulate income or pay it out is one of the finer points best left to your financial adviser. State laws enter in here. Either way, however, you save plenty of money in taxes:

¶ If the income accumulates, the trust pays only about 20 per cent tax on it. This is probably less than you're paying now if you're taking the money as current income.

¶ If the trust pays out the income to the beneficiary, taxes are even lower. Reason: He's allowed the 10 per cent standard deduction, plus a \$600 personal exemption for himself. (If the beneficiary is your son and if, after those deductions, he still has more than \$600 a year of taxable income, don't despair. You can continue to claim him as a dependent on your *own* return, as long as you're contributing more than one-half his support, and he's under 19 or a full-time student.)

That, briefly, is how a short-term trust works. Unlike most tax-saving schemes, it's feasible even for modest-income taxpayers who get some of their money from property or securities. Naturally, the higher your tax bracket, the more dramatic the savings.

[MORE▶

A friend of mine in the 50 per cent tax bracket—I'll call him Dr. Barton—recently set up just such a trust. About \$1,000 of his \$34,000 taxable income was from dividends on \$20,000 worth of utility stocks. But he was netting only \$500 from the dividend income *after taxes*.

Why Work Harder?

One day he figured out that it would cost him about \$15,000 of before-tax dollars to accumulate \$8,000 over the next ten years for his boy's college education. That's when he hit on the trust idea.

"There must be an easier way," he thought. And with the help of a tax consultant he found one:

The Trust Solution

He created a ten-year trust and transferred the securities to it. Now the trust gets the \$1,000 income and pays a much lower tax—\$180—on it. With the remaining \$820 a year, the trustee pays the annual premium on a ten-year endowment policy for Dr. Barton's son. In 1966, the doctor will recover his securities and the son will get a college fund of almost \$9,000. In the in-

terim, the Barton family will have saved \$3,200 in Federal income taxes.

Such trusts are particularly worth-while for providing educational funds. But they have many other uses. For example, trust income can start a permanent life insurance program for your children. Or it can help support your parents. Or it can benefit your favorite charity.

What's Forbidden

One caution, though: You may *not* use trust income to pay bills you're *legally obliged* to meet. So you couldn't set up a trust that would contribute toward the everyday support of your children. You're legally responsible for such support in any event.

If there are so many benefits available to taxpayers who establish short-term trusts, why hasn't the trust idea gained wider popularity? There are three reasons:

1. Until the 1954 tax law was passed, there were no clear-cut rules indicating what you could and couldn't do legally. Court decisions—often conflicting ones—were about the only guide. So lawyers and [MORE ON 302]

26 WAYS TO SPEED OFFICE TRAFFIC FLOW

By Lois Hoffman

The movement of people through your office can be made more orderly by means of layout changes. Here's a wide variety to choose from

You want to keep people moving smoothly through your office. No long waits for tied-up rooms. No doubling back through congested corridors. No unnecessary steps for you and your aides.

That's what you want. How can you get it?

The experience of hundreds of doctors can help answer the question for you. It's summed up in the practical suggestions presented here.

Not all of the following tips can be applied in every office. Many represent alternative solutions to a single problem. Some will help only if you're planning a new building. But a good number can be put into effect in any existing set-up. A few of them, at least, are pretty sure to make sense in your particular office and type of practice.

[MORE▶

Planning Traffic Flow



► Station your aide where she can oversee in- and out-traffic without leaving her post. This usually means putting her close to the main door, near the reception room. Her reception desk should be the first thing patients see when entering, the last when leaving.

► Have traffic pass *around* the aide's station, not through it. Don't, for example, station your secretary in the reception room itself unless (as in the accompanying diagram) you can partition off one corner to give her a private work area. Another possibility, if you can't spare a separate room: Put her desk and files in one end of the entrance hall.

► Provide a small alcove near the entrance where patients can leave their wraps. Then, when departing, they won't have to backtrack through the reception room.

► Put the patients' lavatory where it can be reached easily from both the reception and treatment areas. Don't put it directly off the reception room; that's too public a spot. Suggested location: next to the laboratory, with a pass-through for urine specimens.

in the Reception Area

- Place your laboratory close to the aide's station. Then your girl won't have to race down the hall from the lab whenever the phone rings. And if you have two aides, your laboratory technician can keep her eye on the reception desk while your secretary is out to lunch.
- Locate your consultation room near the entrance, so that detail men and other people who don't have to be seen in an examining room can whisk in and out quickly.

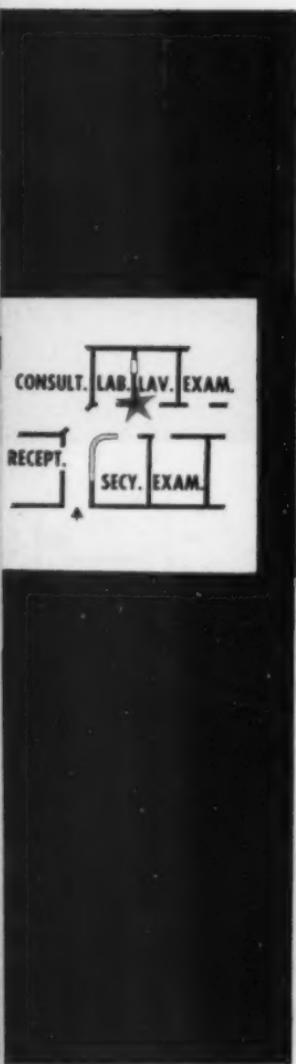
► Shield the entrance from the reception room by a jog in the hall, by proper placement of inside doors, or by a partition. Thus, unseen from the reception room, the doctor and special visitors can go straight to the treatment area. This sketch shows one possible layout, with a door leading into the consultation room from the foyer.

► Try to provide a back entrance that can be used by the office staff, delivery men, and emergency cases. This arrangement eliminates a good deal of traffic through the reception area. If possible, put the second door where your receptionist—but not waiting patients—can keep track of people who come in.

[MORE ▶]



Planning Traffic Flow



► Use identifying doorplates or room numbers to help patients find treatment rooms, lavatories, etc. Or paint the doors different colors: for example, tan for consultation rooms, blue for treatment rooms. Your aide can then ask patients to go down the hall to "the first tan door on the right."

► Have the doors of all rooms open directly into the corridor—not into other rooms. You promote traffic snarls if you make your patients go through an examining room, say, to reach the lavatory.

► Consider installing small signal lights at each examining-room door. Hand-operated by doctor and nurse, they show when the patient is ready for an examination, when the doctor is with the patient, and when the room is free. The receptionist can then route traffic accordingly.

► Provide at least two examining rooms per doctor. Then your aide won't have to wait for a patient to leave before she can usher the next one in. (OB men and pediatricians often need three or four examining rooms.)

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Flow to the Treatment Area

- Try to provide a separate room for recovery and time-consuming tests (ECG, BMR, etc.). While such procedures are going on, traffic can flow as usual in the rest of the treatment area. In case of need, the recovery room can double as an extra examining room.
- Put a screen or curtain (if not a regular dressing room) in one corner of each examining room. Your nurse can get the room ready for the next examination, while the patient dresses in privacy. As soon as he leaves, another visitor is shown in.

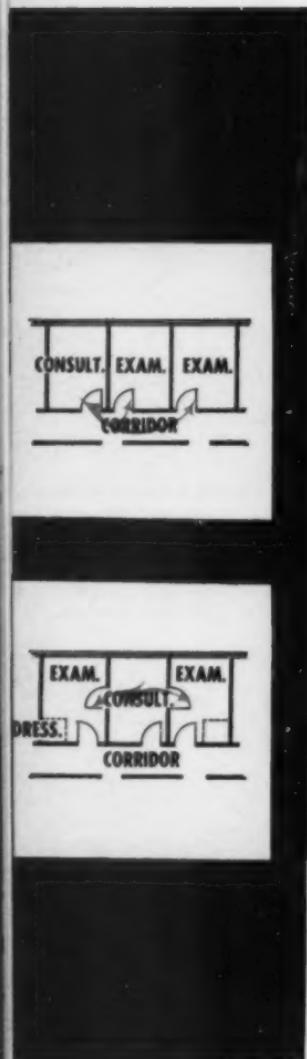
► Allow plenty of passage space in corridors. A three-foot space is the *minimum* passage for two persons; four feet is better.

► Store equipment and supplies right where they're used, to eliminate fetch-and-carry steps. Stock the most commonly used instruments in each examining room: They can go in the drawers of your examining table or in a cabinet beside it. Your aide's business machines, office supplies, and files should be convenient to her desk.

[MORE ►]



Planning Traffic Flow Within



Each of the five treatment-area arrangements shown here has certain advantages in terms of traffic flow. At least one of them should suit your practice methods—and your building budget.*

► Adjoining consultation and examining rooms open off a single hall—a simple and economical set-up. There's only one door in each room, so patients find their way with no trouble. Examining-room doors open the "wrong" way, so that a disrobing patient can't be seen easily from the hall. (Arrows show the doctor's usual path.)

► Adjoining consultation and examining rooms have interconnecting doors. This cuts traffic in the corridor. There's some chance, however, that a patient might stray back into the consultation room unless the hall door in the examining room is clearly marked.

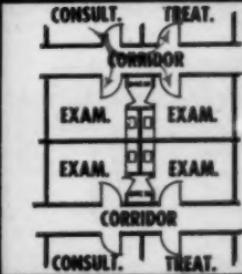
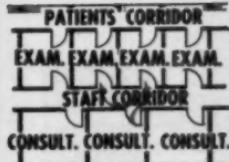
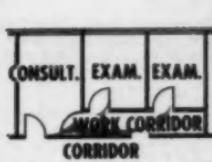
*The floor plans on these two pages are based on portions of a new book, "Doctors' Offices & Clinics: Medical & Dental," by Paul Hayden Kirk and Eugene D. Sternberg. Plans 1, 4, and 5 on pages 122-123 were also adapted from that book. The material is used here with the permission of the publishers, the Reinhold Publishing Corporation, New York.

Within the Treatment Area

► Local traffic circulates in a private work corridor. This arrangement is obviously somewhat expensive because it requires extra floor space. (There may be room for a nurse's station in the work corridor.)

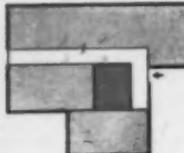
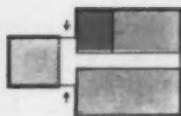
► Patients use one corridor, the staff another. This arrangement is elaborate and expensive, but sometimes very practical. The examining rooms are also used for consultations: Neither the doctor nor the patient has to shuttle between two rooms during the visit. The rooms labeled "Consult" are used only for telephoning, dictating correspondence, and visits with detail men.

► Examining rooms are located in the center of a fairly large building. Consultation rooms, special treatment rooms, etc., are placed around the periphery. Double corridors are costly, but you save a little money by banking most of the plumbing in the core. The dressing-room doors lock from the examining-room side; thus a patient can't barge into the wrong room when he's finished dressing. [MORE ▶]



Planning Traffic Flow Through Your Office

- AIDE**
(Reception desk, business office, laboratory, and sometimes BMR, X-ray, and dark rooms)
- DOCTOR**
(Consultation, examining, and treatment rooms)
- PATIENTS**
(Reception room)



The major rooms in any medical office fall into three categories, depending on who uses them most: the aide, the doctor, or the patients. (See color key at left.)

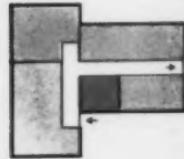
Obviously, your traffic problem is simplified if you keep the rooms in each category close together. The five stylized floor plans on these pages show some of the ways in which the principal areas can be arranged efficiently in relation to one another.

► Single-wing plan puts the aide near the center of the office, where she can control all traffic. This is an economical arrangement, since a short corridor serves a proportionately large number of rooms in the treatment area. It's best suited to a one- or two-man office. If the corridor were extended much farther, patients and staff would have too long a walk to reach rooms at the far end.

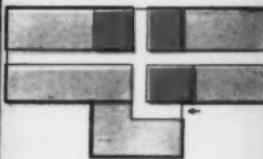
► L-shaped corridor helps set the reception room off from the treatment area while affording the aide excellent control of both. Like Plan I, this layout is most suitable for a small office.

Flow Through the Whole Building

► T-shaped plan can be used to avoid all doubling back through the reception area. From the consultation room (upper left) the patient goes to the treatment wing. When his visit is over, he can discuss business matters with the aide at the reception-desk window on the treatment-wing side. He then leaves by the side door.

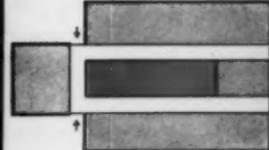


► Double-wing arrangement keeps the reception desk near the center of the building. Each of the two main corridors is used only by persons who have business in that wing. One or two doctors can practice in each wing. The laboratory and BMR-ECG room are centrally located.



► Central core contains the rooms used in common by all the doctors: reception desk, business office, laboratory, X-ray and dark rooms, and surgery. Each of these rooms can be reached from either corridor. Such a plan is economical only for groups of four to ten men. In a larger building, the reception room might be put in the central core, with other facilities used in common spotted around the periphery.

END



They've Got You on an Ethic

THIS ARTICLE is the second of several on medical ethics. The first, published in February, stated the case for "a realistic view of the profit motive in medicine." In succeeding articles, Mr. Williams will suggest further realistic recording of the Principles of Medical Ethics, due to be revised by the House of Delegates of the American Medical Association this coming June. His articles on this subject are copyrighted, 1956, by Medical Economics, Inc., Oradell, N.J. They may not be reproduced, quoted, or paraphrased in whole or in part in any manner whatsoever without the written permission of the copyright owner.

Do you know the first principle of the Principles of Medical Ethics?

You should. It's been the starting point recently for some lively discussions about fees. It reads:

"The prime object of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration."

In all the current hullabaloo (fees are "too high," "too low," "just right"), a few doctors have been at pains to point out that the code doesn't say, "Financial gain is of no consideration."

It would be psychologically sounder to restate this controversial first principle as follows:

"The object of the physician in the practice of medicine is to achieve an honorable and rewarding way of life in the service of humanity."

The old service-above-self way of saying it has the advantage of encompassing a technique for personal success: It stresses service to others as a pleasant

an Ethical Tightrope



Balancing public service and private gain would be no problem—if it weren't for a 1912 addendum to the A.M.A. Principles of Medical Ethics

By Greer Williams

means of achieving your own desires. In other words, you do well through doing good—and everyone is satisfied.

But the old way has a serious defect: It isn't true to human nature. And doctors *are* human.

It would be ideal if you could put service above self. But can you truthfully claim that you do? Wouldn't it be more straightforward to concede a reasonable degree of self-interest and not pretend that it doesn't exist or that it's quite incidental?

As I've restated it, the first principle of medical ethics would not eliminate charity from your way of life. The reward for caring for your fellow man when he's sick would continue to be both spiritual and financial.

"So what?" you may ask. "What do I care whether the A.M.A. code puts my interests first, last, or not at all? I know my responsibilities without being told."

[MORE▶]

THEY'VE GOT YOU ON A TIGHTROPE

True enough. But you're a practical man. And the question has practical implications:

Ever since the physician attracted his first patient away from the witch doctor, his conscience has been plagued by the problem of how much to charge and how to collect. You want to keep your patients happy; yet you want to be paid what you think you're worth.

It's not an easy problem to resolve. People instinctively resent paying for something they don't want: namely, sickness. So you're constantly open to charges of exploiting the patient's misfortune.

Untenable Position

Because medical treatment can't be given wholly as an act of charity, some doctors behave as if making money were a disgrace. Some have told me that the only thing that keeps them from being really happy in the practice of medicine is the fact that they're compelled to bother their patients about money.

Part of the trouble, I suspect, is that in trying to live up to the first principle of medical ethics, these men find themselves forced into an untenable position. For

the code, when freely interpreted, *seems* to say to you and your patients that money is not important; whereas everyone knows it is important.

That's why the first principle as it now stands is misleading. That's why it needs to be rewritten.

Where It Originated

The concept of service above self in medicine has not been handed down over the centuries, as is commonly assumed. On the contrary, it is a twentieth century innovation in your code of ethics.

I've just gone back and read the Oath of Hippocrates, in both its pagan and Christian forms. In each form, the doctor must swear to help and never harm the sick. But neither version of the oath mentions free service to humanity or subordinates financial gain.

When, then, was the service-above-self principle first stated?

To begin with, the term "medical ethics" didn't exist until 1803, when Sir Thomas Percival used it as a title for a treatise on professional conduct. Percival clearly assumed that the physician would work in charity hos-

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pitals as well as in private practice. But he took a businesslike view of the doctor's motives:

"Wealth, rank, and independence, with all the benefits resulting from them, are the primary ends which he holds in view, and they are interesting, wise, and laudable. But knowledge, benevolence, and active virtue—the means to be adopted in their acquisition—are of still higher estimation."

Percival's End

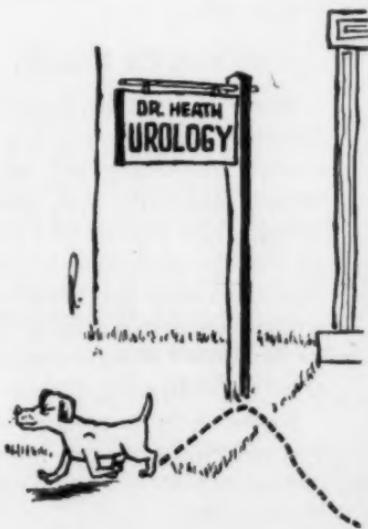
How clearly Percival understood human motivation! Note his realistic distinction between *ends* and *means*. Wealth, he said, is a primary end, to be achieved by means of knowledge and benevolence . . . (You can learn a lot from reading history.)

So it wasn't Percival who subordinated financial gain. Nor was it the A.M.A. founding fathers, who in 1847 adopted a short version of Percival's "Medical Ethics" as the first American medical code. They were, the record shows, pleasantly emphatic about the obligations of patients to their physicians, including an "enduring sense of the value of the services ren-

dered...that no mere pecuniary acknowledgement can repay." Doctors, they agreed, had rights as well as duties.

The code was revised in 1903 and re-entitled "Principles of Medical Ethics." But it wasn't until major revisions were made in 1912 that the first principle emerged pretty much as it now stands. Humanity was exalted. Money was played down. Medicine mounted the marble pedestal and planted the laurel wreath on its brow.

Why was this done?
Those were the good old days



THEY'VE GOT YOU ON A TIGHTROPE

of the family doctor—a Golden Age of medicine, as many recall it. But it was also a Dark Age from the standpoint of medical morality. The diploma mills had ground out cheap "M.D.s" by the thousands. The proprietary hospitals were reminiscent of charnel houses. Cancer quacks were everywhere. Patent medicine was king. The truss companies were doing a bulging business, pushing in ruptures and kicking back to doctors on all sides. Fee splitting among the doctors themselves was rampant. A few surgical slickers even employed cappers and steerers to direct country folks to their offices.

Out With the Rascals!

Horrified at all this rascality, American medicine underwent a moral awakening and began setting standards and taking pledges right and left. The good men of the profession couldn't repeat too often that theirs was a noble, dedicated calling. The profit motive? It was a disgrace! It led to profiteering.

So they rewrote medical ethics—and tried to rewrite human nature—in their effort to control the situation.

It is to their credit that badly needed reforms were accomplished. Today, as a result, the great majority of physicians are graduates of *approved* medical schools and they practice in a manner *approved* by their county medical societies.

Profits Out, Too

But the profit motive remains implicitly *disapproved*. And this is, to say the least, unrealistic.

Denying reality does not achieve the ideal. On the contrary, it invites charges of hypocrisy.

Why? Because people recognize that talking about virtue doesn't necessarily make you virtuous. And because people aren't impressed when you make a virtue of necessity.

The problem isn't one of choosing between selflessness and selfishness. What matters is where you put the emphasis.

Honest Man's Shift

Shifting this emphasis from confused "selflessness" to enlightened selfishness won't make you more of a businessman or less of a professional man. It'll simply make you a franker, more convincing person.

END

Now look what they've done in Los Angeles!

A Medical Convention For John Q. Public

By Claron Oakley

"I can remember when the medical profession kept its inner secrets locked up with a triple-ply chastity belt. But with meetings like this, we're thrusting out a key to the lay public—and look at them grab hold!"

That was the comment of one Los Angeles physician as he watched the milling throngs drawn by his medical society's precedent-shattering medical convention for the laity.

"If this idea catches on in other sections of the country," he added, "it's going to tear down forever the old Iron Curtain between doctors and the public."

What's behind this thumping endorsement? What made L.A. doctors sponsor their own highly professional version of the old-time medicine show? What did they get out of it?

Let's look a little closer and see:

When their eighty-fifth anniversary rolled around early this year, doctors of the Los Angeles County Medical Association decided to shoot off a double-

VISITORS at the rate
of 2,000 an hour
poured through the
gates every day.



MEDICAL CONVENTION FOR JOHN Q.

barreled salute. First they staged a regular medical convention for physicians. Then they staged a special one for laymen. They gave it lots of planning and lots of ballyhoo. It was public relations, California style.

Box-Office Smash

They called it the Cavalcade of Health and Medical Progress, and the ten-day show was a box-office smash. A crowd equal to the population of Salt Lake City

or Omaha poured into Los Angeles' sprawling Shrine Auditorium to find out what makes medicine tick. And if this writer's interviews are any indication, none of them went away disappointed.

To get inside, visitors paid a \$1 admission fee (50 cents for children). Then they pushed into a convention hall crammed with exhibits, motion pictures, and lecturing M.D.s. From booths dispensing free goat's milk to bloody displays of fresh



NO, NOT AN INTERNE, an internist patiently explains. The woman has just said: "I always thought you were men who practiced in hospitals because you didn't have enough experience to open offices outside."



HOW TO SPOT QUACKS is the theme of this exhibit lent by the A.M.A. The junior high school students here are taking notes for the term paper they'll be asked to write when they return to the classroom.

pathology, the laymen saw practically every sight that a doctor sees at a convention of his own.

Technical Spree

They witnessed demonstrations of an artificial kidney. They studied techniques of natural childbirth. They learned how to recognize diseases of the fingernails. In all, they visited more than 350 scientific exhibits.

Were they chilled or charmed by what they saw? Let's hear what some of them say:

"Next month I'm going to have my seventh baby. You'll never believe it, but it wasn't until today that I actually *saw* how labor begins. Now I'm more excited about this baby than I ever was about the other six."

From a pretty co-ed at the fresh pathology exhibit: "Both my grandmother and my mother died of cancer of the breast. Believe me, I've had more than a passing interest in it. But this pathologist today made it really clear to me for the first time how



SOUND EFFECTS help to make this replica of an operation popular with visitors. The man standing at left is wearing an ear set through which he hears a complete cholecystectomy being described by tape recorder.



BIGGEST SUCCESS was the life expectancy machine. Here a woman of 60 learns what her expectancy is now and what it would have been in 1900. The twenty-year difference is due to improved medical care, she learns.

MEDICAL CONVENTION FOR JOHN Q.



PROGRESS OF G.P. is highlighted by a display of equipment. On the left: the meager diagnostic tools of a family physician eighty-five years ago. On the right: the battery of diagnostic and therapeutic equipment that's available to him today.



AUDIENCE PARTICIPATION went with every film. The woman standing has just asked, "Is it my heart that makes my legs throb all night?" The doctor's reply: "Nocturnal leg pains can mean many things. You'd better report them to your family doctor."

breast cancer acts, what my chances are of avoiding it, and what's being done to beat it."

At the conclusion of a movie and lecture on appendicitis, I overheard a man remark that he had just had his appendix out six months before. "It cost me a hundred and fifty," he said, "and after seeing that guy maneuver the scalpel in the movie just now—well, I decided I wouldn't tackle the job for ten times the price."

I quoted this remark to the young surgeon who had just presented the lecture. He grinned and said:

"That's exactly what makes this meeting such a step forward. A person sits here in the theatre and sees an appendix removed. He sees the preparations that must be made and the team it takes to do it. He comes away with a new appreciation of the fact that surgery and medical care are really worth what they cost."

"Yes," agreed Dermatologist Paul D. Foster, general chairman of the convention, "we hope that appreciation does come. But that's not our main motive in putting on this show."

"We want people to know

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everything about medicine that doesn't take medical training to understand. We want to eliminate the usual technical gibberish. We realize that what people don't know *can* hurt them."

With that in mind, Dr. Foster and his colleagues set about providing clinical knowledge in surprising depth. For example, they established three separate theatres in the exhibit hall. All three put on films and lectures that, on any one day, covered just one broad subject.

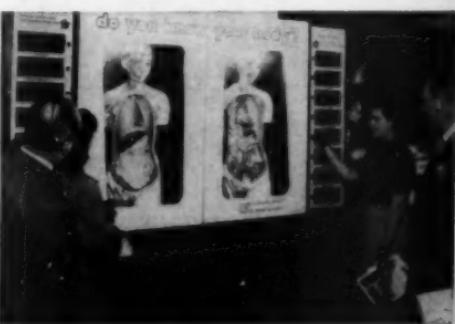
To staff the three theatres, Los Angeles doctors called on such well-known outsiders as Irvine Page, Walter Alvarez, and Assistant Surgeon General David Price. In addition, they drew on the faculties of the city's three medical schools. All the speakers were instructed to mince no clinical words.

"In fact," says Dr. Foster, "we rather expected to have a few cases of fainting or reverse peristalsis. But not once during the whole ten days did we have to use the two ambulances we had standing by."

When each lecture and doctor-narrated movie was over, the audience got a chance to ask questions. "It was the worst in-



SO THAT'S A GALLSTONE! exclaims a wide-eyed woman (front center) at the fresh pathology exhibit. Later she confided to other visitors: "I've had them taken out of me twice—but this is the first time anyone ever showed me what they look like."



ORGAN FINDER helps patients learn the anatomy of their own bodies. By pressing a button, they can light up any bodily organ and a table describing its functions. The woman here is looking at appendixes. She'd had her own out the month before.

MEDICAL CONVENTION FOR JOHN Q.

terrogation I've had since I took the orals for my Boards," said one speaker.

"But it amazed me," he added, "how much curiosity people had about little things I assumed they knew already. I think it's a wonderful service we're performing here."

So did the other doctors present, including the most distinguished out-of-towners. A.M.A. President Elmer Hess was one of them. He estimates that his lectures, press conferences, and

TV appearances during the convention put him in contact with more than 2½ million people. And he adds:

"If I had my way, every county medical society in the country would do what Los Angeles has done."

Can It Be Done?

But can other medical societies do the same thing without having a sizable bankroll and three medical schools in their back yard? The men behind the

What They Looked at In Los Angeles

You might think that these exhibits came straight from a clinical session of the A.M.A. Actually, they're a sampling of the more than 350 exhibits seen by a quarter of a million laymen at the Cavalcade of Health and Medical Progress in Los Angeles.

Exhibitor
Air Pollution Committee
American Association of Blood Banks
American Cancer Society
American Medical Association
American Physical Therapy Association
American Veterinary Medical Association
Arthritis and Rheumatism Foundation
Braille Institute
California Institute of Technology

Exhibit
Chemical analysis of smog
Blood clearinghouse at work
How cancer quacks kill
Disease-carrying insects
Rehabilitation methods
Laboratory-animal care
Relieving arthritic patients
Rehabilitation of the blind
Blood substitutes

Los Angeles convention think so. Here's their advice to smaller medical communities:

1. Get your biggest scientific exhibits from the A.M.A., the American Cancer Society, the Polio Foundation, the Army, Navy, Air Force, and such. Really spectacular exhibits are yours for the asking. All you pay is the freight charge to and from the point of origin.

2. Don't overlook home-grown exhibits—pictorial reports from local hospitals, displays by com-

munity health agencies, and so on. When you start surveying your own town, you may be amazed at how many suitable exhibitors you find.

Fine-Tooth Comb

3. Defray major expenses by devoting part of your hall to commercial exhibits. But screen them with a fine-tooth comb. "In Los Angeles," says one man, "we unwittingly admitted several firms whose products turned out to be questionable. Yet

Exhibitor

California Institute of Technology
California Public Health Department
California Society of Plastic Surgeons
Cancer Prevention Society
Catholic Hospital Association
Cedars of Lebanon Hospital
Childrens Hospital
College of Medical Evangelists
College of Medical Evangelists
Crippled Children's Society
Good Samaritan Hospital
Ileostomy Club
Lockheed Aircraft
Los Angeles County Dental Association
Los Angeles County Heart Association
Los Angeles County Medical Association
Los Angeles Diabetes Association
Mental Health Foundation
Multiple Sclerosis Society
Muscular Dystrophy Association
National Infantile Paralysis Foundation
Orthopaedic Hospital
Richfield Oil Company
Sister Kenny Foundation
University of California at Los Angeles
University of Southern California
U.S. Army Medical Department
Veterans Administration

Exhibit

Electron-micrographs of sperm
Fluoridation of water
Applications of plastic surgery
Cancer detection programs
O.R. with sound effects
Artificial lung in action
Treatment of children with polio
Development of embryos
Human nervous system
Rehabilitation of crippled children
Electroencephalography
Colostomy and ileostomy
Aero-medical research
Progress in dentistry
Heart valve operation
Gross pathology exhibit
Treatment of diabetics
Problems of mental health
Treatment of multiple sclerosis
Treatment of muscular dystrophy
Polio patients in community hospitals
Pool therapy in polio
Peritoneoscopy
The Kenny treatment for polio
The injured-brain child
Research aspects of medical training
Traumatic injuries and their care
Tumors of the head and neck

once they were in, the public assumed their products had our full approval."

4. Publicize your plan far in advance by working closely with the local press, educators, and civic leaders. "Our Los Angeles Cavalcade monopolized newspaper space for ten straight days," says the same man, "simply because we convinced the editors that the only thing people are more interested in than the weather is their health. Then we won the support of both public and private schools by arranging special performances for students and teachers. As for civic leaders, they joined us by declaring a simultaneous Community Health Week. This meant a great deal of free administrative and promotional assistance."

5. Give the public a souvenir

program that will leave them with more than just a memory of what they've seen. "Our bound program in Los Angeles is designed for permanent reference. It tells how to get a doctor in an emergency, how to choose a health insurance plan, all about first aid, and lots more."

Sure-Fire Bet

6. "Maybe this is pure Hollywood, but we even elected a Cavalcade Queen. All our candidates came from the local schools of nursing. The winner's pretty face got us loads of free newspaper and television spots.

"We established mass rapport in Los Angeles as we never have before," this observer concludes. "Any medical community that doesn't seriously consider the idea is missing out on a sure-fire bet."

END

Following Orders

My doctor says that eating cake
Is the last thing I should do.
So just before I go to bed
I eat a piece or two.

—EDNA MAE BUSH

A Sample Tax Return As Filled In by a Physician

By John R. Lapham

You'll be filing a newly revised Form 1040 next month. The important changes are pointed out—and explained—on this typical doctor's return

The sample Federal income tax return shown on the following pages has been prepared on the new Form 1040. It's for a physician I'll call John A. Blaine.

Dr. Blaine, a 54-year-old obstetrician, lives with his wife and three children in a town called Highwell, Md. His practice last year netted him about \$15,000 on a gross of about \$24,000. He also had some additional investment income.

The doctor has his main office at a downtown location. He also maintains a part-time office in his suburban home. This occupies about 25 per cent of the ten-room house; so he takes as a business deduction 25 per cent of all expenses incurred for the building as a whole—e.g., real estate taxes.

If you study his return, you may find many ways in which to compare it with your own. [MORE▶

THE AUTHOR is associated with Professional Business Management, a Washington, D.C., firm of tax and medical management consultants.

FORM 1040 U. S. Treasury Department Internal Revenue Service	U. S. INDIVIDUAL INCOME TAX RETURN For Calendar Year or other taxable year beginning 1955, and ending 1955 <small>(Please type or print clearly)</small>	1955
<small>NAME (IF THIS IS A JOINT RETURN OF HUSBAND AND WIFE, USE FIRST NAMES OF BOTH)</small> John A. and Mary Ann Blaine <small>BOTH ADDRESSES (NUMBER AND STREET OR RURAL ROUTE)</small> 201 Peach Street, <small>TOWN OR CITY</small> Highwell, <small>STATE OR PROVINCE</small> James, Maryland <small>YOUR SOCIAL SECURITY NO. AND OCCUPATION</small> Physician Housewife		
Exempt Bonds In Sight Special computation Tax due or refund Taxpayer sign here Preparer (either the taxpayer) sign here	If Income Was All From Wages, Use Pages 1 and 2 Only. If Such Income Was Less Than \$5,000, You May Need To Use Page 1 Only. See Page 3 of the Instructions.	
	1. Check blocks which apply. Check for wife if she had no income or her income is included in this return. 2. List names of your children who qualify as dependents; give address if different from yours. James E. John A. Jr. Gloria Jean 3. Enter number of exemptions claimed for other persons listed at top of page 2. 4. Enter the total number of exemptions claimed on line 1. 1 5. Enter all wages, salaries, bonuses, commissions, and other compensation received in 1955, before payroll deductions. Outside salesmen and persons claiming traveling, transportation, or reimbursed expenses, see instructions, page 5. <small>Employee's Name</small> <small>Where Employed (City and State)</small> Mt. High Hospital, Highwell, Mi. \$ 800 \$.32 <small>Wages, etc.</small> <small>Income Tax Withholding</small>	
	6. Less: Excludable "Sick Pay" in line 5 (See instructions, page 5.) \$ 600 \$.52 7. Balance (line 5 less line 6) \$ 800 8. Profit (or loss) from business (from separate Schedule C) 15,024 9. Profit (or loss) from farming (from separate Schedule F) 695 10. Other income (or loss) from page 3. \$ 16,369 ADJUSTED GROSS INCOME (sum of lines 7, 8, 9, and 10)	
	<small>Unmarried or legally separated persons qualifying as Head of Household, see instructions, page 14, and check here <input type="checkbox"/></small> <small>Widows and widowers who are entitled to the special tax computation, see instructions, page 14, and check here <input type="checkbox"/></small>	
	<small>IF INCOME ON LINE 11 IS UNDER \$5,000, AND YOU DO NOT ITEMIZE DEDUCTIONS, USE TAX TABLE ON PAGE 16 OF INSTRUCTIONS. IF INCOME IS \$5,000 OR MORE, OR IF YOU ITEMIZE DEDUCTIONS, COMPUTE YOUR TAX ON PAGE 6.</small>	
	12. Enter tax from the Tax Table, or from line 9, page 2. Please check if you use Tax Table <input type="checkbox"/> <small>H Income was all from wages, salaries, etc. from lines 5 through 15.</small> 13. (a) Dividends received credit (line 5 of Schedule J) \$ 4 (b) Retirement income credit (line 12 of Schedule 10) \$ 4 14. Balance (line 12 less line 13) \$ 2,433 15. Enter your self-employment tax from separate Schedule C or F. \$ 2,433 16. Sum of lines 14 and 15. \$ 2,433 17. (a) Tax withheld (line 5 above). Attach Forms W-2 (Copy B). \$.52 (b) Payments and credits on 1955 Declaration of Estimated Tax (see instructions, page 13). 2,400 \$ 2,452 District Director's office where paid Baltimore, Md. 18. If your tax (line 12 or 16) is larger than your payments (line 17), enter the balance here \$ <small>Send this balance with your return to "Internal Revenue Service." If less than \$2.00, do not remit.</small> 19. If your payments (line 17) are larger than your tax (line 12 or 16), enter the overpayment here \$ <small>If less than \$2.00, it will be refunded only upon application. See instructions, page 15.</small> \$ 19	
<small>Enter amount of line 19 if you were entitled to \$ 19 refund. <input type="checkbox"/></small> <small>If your wife (husband) making a separate return for 1955? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> If "Yes," enter his name and address. Professional Business Management, Washington, D.C. <input type="checkbox"/> Do you owe one or more Federal tax for prior years? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</small>		
<small>I declare under the penalties of perjury that this return (including any accompanying schedules and statements) has been examined by me and is the best of my knowledge and belief, true, correct, and complete. I declare that my wife and I are the only taxpayers, male and female, whose names appear on this return, and that we have signed this return together. John A. Blaine 3/3/56 Mary Ann Blaine 3/3/56</small> <small>To ensure split-income benefits, husband and wife must include all their income and, even though only one has income, BOTH MUST SIGN.</small> <small>I declare under the penalties of perjury that I prepared this return for the person(s) named herein, and that this return (including any accompanying schedules and statements) is, to the best of my knowledge and belief, a true, correct, and complete return based on all the information relating to the matters required for the preparation of which I have any knowledge. John R. Tugman 1009 30th St. N.W., Washington, D.C. 3/3/56</small>		

The doctor's son John is 20 and in college. He earned \$850 last summer, so he must file his own income tax return. But since Dr. Blaine contributes more than one-half of the boy's support, and since John is a full-time student, the doctor can still claim him as a dependent.

A new income breakdown is called for on page 1 of the revised Form 1040. Profit from business, profit from farming, and "other income" (items 8, 9, and 10) were formerly lumped together. The itemization required here is designed to make it easier for the Internal Revenue Service to spot returns showing a lot of "other income" meriting detailed auditing.

Rounding off figures to the nearest dollar is now permitted. Thus an item of \$10.49 becomes \$10, while one of \$10.50 or more becomes \$11. Eliminating the pennies saves time for both you and the Treasury—and the tax gain or loss will rarely exceed \$1. But if you round off *any* figures on your return, remember you must do so with all of them.

[MORE ►]

New Form 1040, Page 2

Page 2

EXEMPTIONS FOR PERSONS OTHER THAN YOUR WIFE AND CHILDREN

Name	Relationship	Old dependent live in your home?	Old dependent have disability or are 65 or more?	Amount YOU spent for dependent less than 100% more than \$300	Amount spent by OTHERS including government, local and state funds
William R. Blaine (Form 2120 attached)	Father	No	No	\$ 200	\$ 1,500

Enter on line 2, page 1, the number of exemptions claimed above.

→ If an exemption is based on a multiple-support agreement of a group of persons, attach information described on page 5 of instructions.
ITEMIZED DEDUCTIONS—IF YOU DO NOT USE TAX TABLE OR STANDARD DEDUCTION

Married and Wife (Not Legally Separated) File Separate Returns and Use Itemized Deductions, the Other Must Also File
 Describe deductions and state in whom paid. If more space is needed, attach additional sheets. Please put your name and address on any attachments.

Contributions	First Church of Highwell Mt. High Hospital building fund Miscellaneous. (See schedule attached)	\$420 100 150	
	Total Contributions (not to exceed 20 percent of line 11, page 1, except in special cases described on page 11 of instructions)	\$ 670	
Interest	Mortgage on residence, First National Bank (75% personal)		
Taxes	Maryland real estate (75% personal) Maryland state income Maryland automobile (25% personal) Maryland sales and personal gasoline	\$313 264 4 84 Total	297
Medical and dental expense (If 65 or over, see instructions, page 12)	Subtract itemized list. Do not enter any expenses compensated by insurance or otherwise. 1. Cost of medicines and drugs, in excess of 1 percent of line 11, page 1..... 2. Other medical and dental expenses..... 3. Total..... 4. Enter 7 percent of line 11, page 1..... 5. Allowable amount (excess of line 3 over line 4). (See instructions, page 19, for limitations)	\$ 590 590 491 99	
Child care	Expenses for care of children and certain other dependents not to exceed \$600 (See page 13 of instructions and attach statement)		
Losses from fire, storm, or other casualty, or theft	Damages to garage from falling tree during storm. Not covered by insurance		100
Miscellaneous	Total losses (not compensated by insurance or otherwise) Rental of safe deposit box for stocks Wall Street Journal	\$ 6 20 Total	26
	TOTAL DEDUCTIONS (Enter on line 3 of Tax Computation, below)	\$ 1,857	

TAX COMPUTATION—IF YOU DO NOT USE THE TAX TABLE

1. Enter Adjusted Gross Income from line 11, page 1	\$ 16,369
2. If deductions are itemized above, enter total of such deductions. If deductions are not itemized and line 1, above, is \$5,000 or more: (a) married persons filing separately enter \$500; (b) all others enter 10 percent of line 1, but not more than \$1,000.	1,857
3. Balance (line 1 less line 2)	\$ 14,512
4. Multiply \$600 by total number of exemptions claimed on line 4, page 1	3,600
5. TAXABLE INCOME (line 3 less line 4)	\$ 10,912
6. Tax on amount on line 5. Use appropriate Tax Rate Schedule on page 14 of instructions	\$ 2,437
7. If you had capital gains and the alternative tax applies, enter the tax from separate Schedule D	\$
8. Tax credits. If you itemized deductions, enter:	
(a) Credit for income tax payments to a foreign country or U. S. possession (Attach Form 1116)	\$
(b) Income tax paid at source on tax-free convert bond interest and credit for partially tax-exempt interest	\$
9. Enter here and on line 12, page 1, the amount shown on line 6 or 7 less amount claimed on line 8	\$ 2,437

Page 2
OTHER
ONE PAGE

Exemption for father is allowed even though Dr. Blaine shoulders less than half his support.

(The doctor and his two brothers each contribute one-third.) Under the present law, any one—but only one—of the sons may claim his father as a dependent for a given year, provided he attaches to his return special "multiple support agreements" signed by the other two. Agreement forms (Form 2120) can be obtained from the Internal Revenue Service.

A personal medical expense deduction can be taken for expenditures (*not* compensated for by insurance) in excess of 3 per cent of adjusted gross income. Here, medical bills come to \$590; that's \$99 more than the \$491 that represents 3 per cent of the doctor's adjusted gross. Dr. Blaine can't deduct for the cost of drugs and medicines, however, since such costs didn't exceed 1 per cent of his adjusted gross.

Deductions for casualty losses will be more common on this year's returns because of the hurricanes and floods of 1955. Generally speaking, you're allowed to deduct the amount of your loss, less any sum recovered from insurance. For more details, see page 231 of this issue. [MORE▶

New Form 1040, Page 3

IF INCOME WAS ALL FROM SALARIES AND WAGES, TEAR OFF THIS PAGE AND FILE ONLY PAGES 1 AND 2.				
Page 3				
Schedule A.—INCOME FROM DIVIDENDS				
1. Name of qualifying corporation declaring dividend (See instructions, page 6, for definition of qualifying corporation): National Color Co., Inc. (Husband) \$.74 Ace Copper Co., Inc. (Husband) .38 Union Motors Co., Inc. (Jointly owned) .24 Logan Co., Inc. (Jointly owned) .80				
2. Total \$.196 3. Exclusion of \$50 (\$ if both husband and wife received dividends, each is entitled to exclude not more than \$50 of his (her) dividends) .92 4. Enter excess, if any, of line 2 over line 3 \$.104 5. Name of nonqualifying corporation declaring dividend: Petworth Association, Inc. .45				
6. Enter total of lines 4 and 5 \$.149				
Schedule B.—INCOME FROM INTEREST				
Name of payer Amount Name of payer Amount First Federal Savings \$.45 \$. Series "E" Bonds .62 Enter total here \$.107				
Schedule D Summary.—GAINS AND LOSSES FROM SALES OR EXCHANGES OF PROPERTY				
1. From sale or exchange of capital assets (from separate Schedule D) \$.156 2. From sale or exchange of property other than capital assets (from separate Schedule D) (206)				
Schedule E.—INCOME FROM PENSIONS OR ANNUITIES (See instructions, page 8)				
Part I.—General Rule 1. Investment in contract \$. 2. Expected return \$. 3. Percentage of income to be excluded (line 1 divided by line 2) % 4. Amount received this year \$. 5. Amount excludable (line 4 multiplied by line 3). 6. Taxable portion (excess, if any, of line 4 over line 5). Part II.—Where your cost will be recovered within three years and your employer has constituted part of the cost 1. Cost of annuity (amounts paid in) \$. 2. Cost received tax-free in past years \$. 3. Remainder of cost (line 1 less line 2) \$. 4. Amount received this year \$. 5. Taxable portion (excess, if any, of line 4 over line 3).				
Schedule G.—INCOME FROM RENTS AND ROYALTIES				
1. Kind and location of property 2. Amount of rent or royalty 3. Depreciation (explain in Schedule C) 4. Expenses (attach separate list) 5. Other expenses (attach separate list) Frame house, \$ 1,500. \$ 480. \$ Interest .224. 1164 Pine Street Insurance .63 Highwell, Md. Taxes .244				
1. Totals \$ 1,500 \$ 480 \$. \$ 531 2. Net profit (or loss) (column 2 less sum of columns 3, 4, and 5) \$.489				
Schedule H.—INCOME FROM PARTNERSHIPS, ESTATES, TRUSTS, AND OTHER SOURCES				
1. Partnership (Name and address). 2. Estate or trust (Name and address). 3. Other sources (state nature). Total income (or loss) from above sources (Enter here and on line 10, page 1) \$.695				
Schedule I.—EXPLANATION OF DEDUCTION FOR DEPRECIATION CLAIMED IN SCHEDULE G				
1. Kind of property (if building, state material of which constructed). Exclude land and other nondepreciable property Frame house, 12/1/53 \$ 12,000. \$ 520. Straight .4% \$.480. 1164 Pine Street Highwell, Md.				

Page 4

IF INCOME WAS ALL FROM SALARIES AND WAGES, TEAR OFF THIS PAGE AND FILE ONLY PAGES 1 AND 2.

Schedule J—DIVIDENDS RECEIVED CREDIT

(See instructions, page 55)

1. Amount of dividends on line 4, Schedule A.....	\$ 104
2. Tentative credit (4 percent of line 1).....	\$ 4

LIMITATIONS ON CREDIT

3. Tax shown on line 12, page 1, plus amount, if any, shown on line 9(b), page 2.....	\$ 2,437
4. 4 percent of taxable income.....	\$ 436
Taxable Income Means	(a) If tax is computed on page 2, the amount shown on line 5, page 2. (b) If capital gains alternative tax applies, the amount shown on line 18, separate Schedule D. (c) If Tax Table is used, the amount shown on line 11, page 1, less 10 percent thereof, and less the deduction for exemptions (\$600 multiplied by the number of exemptions claimed on line 4, page 1).
5. Dividends received credit. Enter here and on line 13(a), page 1, the smallest of the amounts on lines 2, 3, or 4, above.....	\$ 4

Schedule J—Dividends Received Credit Page 14

Dividend income is partially exempt from tax.

Dr. Blaine's portion of dividends received in 1955 was \$154, and his wife's \$42; so he's entitled to the full \$50 exclusion allowed, and she's entitled to a \$42 one. On this joint return, the doctor adds the two exclusions together and enters only the total. Then, in addition to the \$92 exclusion listed, the Blaines are entitled to a so-called dividend "credit." This amounts to 4 per cent of the dividend income that's left after subtracting the \$92 exclusion. Thus, on Schedule J (above), Dr. Blaine takes 4 per cent of \$104 (\$4) as his credit.

[MORE ▶]

New Schedule C

SCHEDULE C
 (Form 1040)

 U. S. Treasury Department—Internal Revenue Service
PROFIT (OR LOSS) FROM BUSINESS OR PROFESSION
 (For Computation of Self-Employment Tax, see Page 2)

1955

Attach this schedule to your Income Tax Return, Form 1040 — Partnerships, Joint Ventures, Etc. Must File On Form 1040
 For Calendar Year 1955, or other taxable year beginning _____, 1955, and ending _____, 1955

Owner's Name and Address

 John A. Blaine, M.D., 201 Beach Street, Highwell, Md.
 See (see Instructions—page 2)

B. Principal business activity: Physician
 (Retail trade, wholesale trade, lawyer, etc.)
 (Principal product or service)

B. Business name: 201 Beach Street, Highwell, James, Maryland
 C. Business address: 410 Main Street, Highwell, James, Maryland
 (Street number or rural route) (City, town, post office)

IMPORTANT—If you had more than one business, a separate page 1 of Schedule C must be completed for each business.

Line (see Instructions—page 2)			
1.	Total receipts \$	23,994	, less allowances, rebates, and returns \$
2.	Inventory at beginning of year	50	
3.	Merchandise purchased \$, less any losses withdrawn from business for personal use \$
4.	Cost of labor (do not include salary paid to yourself)		
5.	Material and supplies		
6.	Other costs (explain in Schedule C-2)		
7.	Total of lines 2 through 6		
8.	Inventory at end of year		
9.	Cost of goods sold (line 7 less line 8)		
10.	Gross profit (line 1 less line 9)		\$ 23,944

OTHER BUSINESS DEDUCTIONS

11.	Salaries and wages not included on line 4 (do not include any paid to yourself)	\$ 3,000
12.	Rent on business property	1,800
13.	Interest on business indebtedness	99
14.	Taxes on business and business property	174
15.	Losses of business property (attach statement)	
16.	Bad debts arising from sales or services	
17.	Depreciation and obsolescence (explain in Schedule C-1)	1,475
18.	Repairs (explain in Schedule C-2)	81
19.	Depletion of mines, oil and gas wells, timber, etc. (attach schedule)	
20.	Amortization of emergency and grain storage facilities (attach statement)	
21.	Other business expenses (explain in Schedule C-2)	2,241
	Total of lines 11 through 21	\$ 8,870
	Net profit (or loss) (line 10 less line 22). Also enter on line 24, page 3 of this schedule, and on line 8, page 1, Form 1040.	\$ 15,074

Schedule C-1. EXPLANATION OF DEPRECIATION FOR DEPRECIATION CLAIMED ON LINE 17

1. Kind of property (if buildings, state material of which constructed). Exclude land and other assets not depreciated.	2. Date acquired	3. Cost or other basis	4. Depreciation claimed (or otherwise deducted) for prior years	5. Method of computing depreciation	6. Rate (%) or life (years)	7. Depreciation for this year
Frame res. and off.	7/1/49	\$ 26,600	\$ 1,092	Straight	7%	\$ 199 (.25%)
Office furniture	7/1/49	2,350	1,282	Straight	10%	235
Office equipment	4/1/50	5,180	2,962	Straight	10%	516
Automobile	12/20/53	2,800	1,050	Declining	4 yrs.	525 (.75%)
						1,475

Schedule C-2. EXPLANATION OF LINES 6, 10, AND 21

Line No.	Description	Amount	Line No.	Description	Amount
		\$			\$
	Schedule attached				

GSR-10-17401-1

Schedule C-2

SCHEDULE C-2

John A. Blaine, M.D.
410 Main Street
Highwell, Maryland

Calendar Year 1953

<u>TAXES</u>		
Social Security		\$ 60
Narcotic license		1
State license		6
Maryland unemployment		3
real estate (2% of total)		<u>104</u>
Line 14	Total.	\$174

<u>REPAIRS</u>			
Professional equipment		\$26	
Electrical	\$120		
Oil burner	100		
	220		
		55	(25%)
Line 18	Total.		\$81

OTHER BUSINESS EXPENSES

<u>Maintenance Expense</u>	\$	
Heat	210	
Light	213	
Water	41	
Telephone	381	
Cleaning	600	
Insurance	153	
Grounds	250	
	<u>1,848</u>	\$462 (25%)

<u>Auto Expense</u>	
Gas, oil, grease, washing	439
Service and repairs	49
Insurance	187
License plates	16
	<hr/>
	691
	518 (75%)

<u>Office Expense</u>	
Medical supplies	\$252
Office supplies and postage	293
Laundry	115
Telephone and answering service	247
Accounting	<u>90</u>
	991

<u>Professional Expense</u>		
Malpractice insurance	124	
Society dues	100	
Journals	40	
		<u>264</u>
Total.		\$2,241

A detailed breakdown of business taxes, repairs, and other business expenses (lines 14, 18, and 21) is given in separate Schedule C-2, which the doctor attaches to his return. In his case, he deducts 75 per cent of automobile expenses and 25 per cent of home repairs and maintenance. [MORE►]

[MORE ►]

New Schedule D

Rearranged Schedule D makes it easier for the taxpayer to figure various kinds of gains and losses. Dr. Blaine's transactions during 1955 left him with one gain and two losses—the latter indicated here by parentheses.

Short-term capital gain of \$401 is partly offset: The doctor subtracts from that gain a \$245 long-term loss. Then he enters his resulting taxable gain (\$156) both here and on page 3 of Form 1040.

Deductible loss resulted when the doctor replaced some of his medical equipment: The selling price added to the depreciation allowance he had taken on previous tax returns totaled only \$3,010. This was \$206 less than the original cost of the equipment. **END**

Mutual Funds Now Offer You Built-In Insurance

By Thomas Owens

Some offer a special package guaranteeing completion of your investment objective if you die. One fund even adds a retirement provision

Mutual funds may become even more popular with doctors who'd rather not manage their own investments. Reason: Many of the funds now offer an attractive new feature—built-in life insurance.

This investment-insurance program is a comparatively recent addition to the "accumulation plans" sponsored by the funds. Under such plans, you invest a predetermined sum in fixed monthly amounts.

Suppose you decide to invest a total of \$10,000 in a fund at the rate of \$100 a month. Under the *insured* plan, you get an added benefit:

If you die after investing only part of the total—\$2,000, say—the fund's insurance company will buy \$8,000 worth of fund shares and turn them over to your beneficiary. So you're sure to reach your investment goal even if you don't live to do it yourself.

Naturally, you're not getting something for nothing. You pay for the insurance feature this way: A small part of your monthly payments is used by the

mutual fund to pay the premium on a decreasing term policy on your life. Premiums generally come to about 75 cents a month per \$1,000 of insurance.

The advantage of the tie-in, of course, is that the insurance policy will always provide enough money to complete your unfinished investment program. As your stake in the fund rises, the amount of insurance in force automatically decreases. And so does the premium.

Accumulation programs differ in details. Some funds, for example, penalize you if you drop out before completing all payments. With almost all funds, you pay a sales fee—or “loading charge”—of 7 or 8 per cent of the total amount you invest; but there are various ways of paying this extra money. So you’ll want to discuss the matter with your investment adviser before making a choice of fund.

While the basic structure of every insured-investment program is as I’ve outlined it, there’s one plan that’s apparently unique. It’s a three-way package offered *not* by a mutual fund, but by an insurance company: the Nationwide Life Insurance Company of Columbus, Ohio (one of the group formerly called Farm Bureau Insurance Companies).

Like the other plans, Nationwide’s combines life insurance coverage with an accumulative program of investments in a fund (Mutual Income Foundation) that has a 7½ per cent loading charge. But, unlike the other investment-insurance plans, this one also provides for a retirement income starting at age 60 or 65.

[MORE▶

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MUTUAL FUNDS

Here's a dollars-and-cents example:

Suppose you're 40 years old and would like to consider retiring at 65. Suppose, too, that you want to save about \$100 a month toward retirement. You set up a twenty-five-year, \$100-a-month investment plan; and you direct that the annual return be automatically reinvested in the fund. (There's no loading charge on reinvested profits.) As soon as you begin, the company insures you for the total amount you plan to invest—about \$30,000.

Basing its estimate on a conservative 3½ per cent return, it figures that your stake in the fund at age 65 should be about \$44,000.

[MORE ▶]

A necdotes

¶ MEDICAL ECONOMICS will pay, until further notice, \$25-\$40 for an acceptable description of the most exciting, amusing, amazing, or embarrassing incident that has occurred in your practice.

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Makes her fancy for daintiness a fact in your prescription success.

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Your patients will appreciate the new LANTEEN Easy-clean applicator for one simple but important reason—unlike other applicators it can be disassembled and cleaned thoroughly. This considerate improvement lets your patient know that you appreciate her fancy for daintiness, while you insist on her observing strict feminine hygiene. Another LANTEEN design for better patient-cooperation.

Easy-clean jelly applicator.



LANTEEN jelly, diaphragms, and jelly-diaphragm sets are distributed by George A. Breon & Company, 1450 Broadway, New York 18, N. Y. (In Canada: E. & A. Martin Research Ltd., 20 Ripley Ave., Toronto, Canada) Manufactured by Esta Medical Laboratories, Inc., Chicago 38, Illinois.

MUTUAL FUNDS

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When you reach 65, the company begins to liquidate your shares. From the proceeds, and from an annuity purchased with a part of your capital, it pays you \$260 a month for life. If you die before your accumulated capital is depleted, the remainder is automatically turned over to your estate.

The Income Varies

That's how the plan works in theory. But your *actual* income at 65 may be more or less than \$260 a month, depending on

what
every
doctor
knows...



You and every Doctor know the financial plight of our medical schools . . . but in the rush of daily practice you may have forgotten about making your 1956 contribution?

Now is the time to make your contribution, either through your Alumni Committee or direct to the American Medical Education Foundation.
Support Medical Education NOW.

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Re-activate the arthritic

Sterane*

Even where hydrocortisone, cortisone, and other agents had failed, prednisolone (STERANE) restored articular mobility and functional capacity to normal in rheumatoid arthritis.¹

Four times more effective than hydrocortisone, and, on the basis of preliminary findings,² superior in potency even to rednisone (cortisone analog), STERANE is also relatively free of such hormonal side effects as edema, hypertension, or hypopotassemia.

Supplied: White, 5 mg. oral tablets, in bottles of 20 and 100. Pink, 1 mg. oral tablets, in bottles of 100. Both are deep-scored and in the distinctive "easy-to-break" size and Pfizer oval shape.

Reference: 1. Bunim, J. J., et al.: J.A.M.A., 157:311, 1955. 2. Forsham, P. H., et al.: Paper presented at First Internat. Conf. on Prednisone and Prednisolone, New York, May 31-June 1, 1955. 3. Perlman, P. L., and Tolokoff, S.: Scientific Exhibit presented at A.M.A. Annual Meet., Atlantic City, June 6-11, 1955.

Pfizer Laboratories Division Chas. Pfizer & Co., Inc., Brooklyn 6, New York

*brand of prednisolone

MUTUAL FUNDS PLUS INSURANCE

whether the fund's assets go up or down. Fundamentally, remember, this is an *investment* program, not an insurance program.

No Growth Fund

Obviously, the Nationwide plan isn't for the doctor who wants a guaranteed, sure-fire annuity. Nor is it for the man whose investment aim is capital appreciation. Mutual Income Foundation is a balanced, con-

servative fund, with a good portion of its assets invested in income stocks that seldom show an appreciable amount of capital growth.

But for the physician who'd like a reasonably sound investment-insurance-retirement package, Nationwide seems to offer unusual flexibility. For example, you can drop out of the plan at any time without penalty. Or you can withdraw your money (for an emergency, say) and



"I just washed him, and I can't do a thing with him!"

If you
excessive
high 1
CYESI
vitami
intrinsic
supplie
readily

Six capsu
Calcium
Calcium
Intrinsic
Vitamin
Vitamin
Thiamine
Riboflavi
Niacinam
Vitamin
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If you find your patients complain excessively of muscle cramps due to high phosphorus intake, prescribe CYESCAPS. Each capsule provides 22 vitamins and minerals plus purified intrinsic factor concentrate; calcium is supplied as calcium lactate, its most readily assimilated form. This well-

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Dosage: 1 or 2 capsules 3 times daily.



a Lederle exclusive, for more rapid and complete absorption. No oils, no paste, no aftertaste.

Six capsules supply:

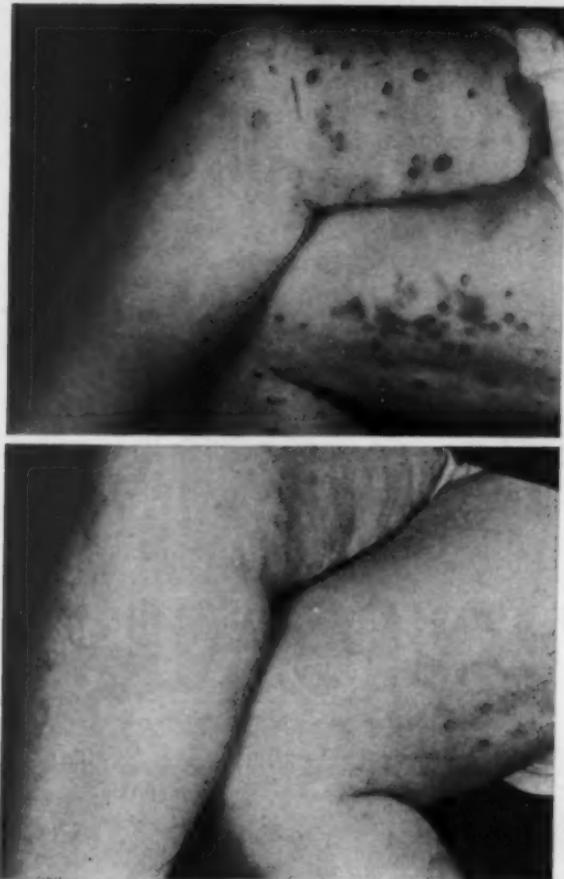
Calcium (as Lactate).....	600 mg.
Calcium Lactate.....	3720 mg.
Intrinsic Factor Concentrate.....	1.5 mg.
Vitamin A.....	6,000 U.S.P. Units
Vitamin D.....	400 U.S.P. Units
Thiamine Mononitrate (B ₁).....	1.5 mg.
Riboflavin (B ₂).....	3 mg.
Niacinamide.....	15 mg.
Vitamin B ₆	6 mcgm.
Ascorbic Acid.....	150 mg.
Folic Acid.....	2 mg.
Pyridoxine HCl (B ₆).....	6 mg.

Calcium Pantothenate.....	6 mg.
Vitamin K (Menadione).....	1.5 mg.
Iron (as FeSO ₄ excised).....	15 I.U.
Vitamin E (as Tocopherol Acetate).....	6 I.U.
Iodine (as KI).....	0.1 mg.
Fluorine (as CaF ₂).....	0.09 mg.
Copper (as CuO).....	0.9 mg.
Potassium (as K ₂ SO ₄).....	5 mg.
Manganese (as MnO ₂).....	0.3 mg.
Magnesium (as MgO).....	0.9 mg.
Molybdenum (as Na ₂ MoO ₄ .2H ₂ O).....	0.15 mg.
Zinc (as ZnO).....	0.5 mg.

*Reg. U.S. Pat. Off.

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Dispensed only in original blue jar.

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MUTUAL FUNDS PLUS INSURANCE

then reinvest it later *without* having to pay a second loading charge.

In addition, Nationwide's insurance pay-off seems fairly liberal: If you die before completing your investment program, the company will pay the insurance money *directly* to your beneficiary. (The other funds, remember, invest such proceeds in fund shares.) If he takes this direct payment, the beneficiary avoids paying the loading charge on an investment that he might prefer to liquidate almost immediately.

Tricked out with their new features, the mutual funds will undoubtedly appeal to many doctor-investors. But don't let the accumulation and insurance trimmings blind you to the basic question: Which investment fund offers you *superior management of your money?*

Look for Evidence

Before entrusting your savings to any one of the funds, study its record. That's the only way to find out whether the managers have ever *proved* themselves superior. **END**

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penicillin

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1,200,000 units, scored, bottles
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Also available: BIGILLIN® • VEE
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zathine penicillin G and 100,000
units of penicillin V, bottles of 36.

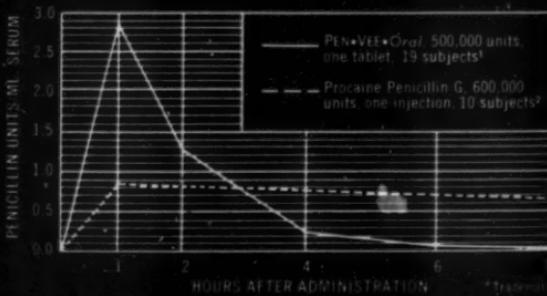
Wright, W.W.: Personal
communication.
Price, A.H.: Personal
communication.

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Syndrox can help to bolster the patient's will power through the "crucial" spots in the dietary regime by depressing the appetite.

Syndrox also produces a feeling of greater energy, efficiency—combats the loss of vitality which is often a result of menus necessarily low in carbohydrates.

SUPPLIED in 5 mg. tablets (scored, green), imprinted 'McNeil'—bottles of 100 and 1000. Also available in a pleasant-tasting elixir (colored amber); each 5 cc. (one teaspoonful) containing 5 mg.—pints and gallons. Samples on request.

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The "Do's" of Low Sodium Diets

You know the "don'ts" of sodium restriction—the list is long. Here are some "do's" to add new zest and flavor and give your patient a diet he can stick to.

Here's what can be used—

Spices and herbs, lemon and lime, variously flavored vinegars. And fresh-ground pepper has a pungency that never came out of a shaker!

Here's how—

Hamburger takes well to a pinch of thyme, another of marjoram. Chicken's delicious with lemon, rosemary, and sweet butter to baste. And broiled steak speaks for itself.

Vegetables are even easier. Your patient may like them livened with vinegar—white wine vinegar with mild flavored vegetables, red with more robust flavors. Broccoli and asparagus are especially good with lemon juice.

If butter is a "must," it's sweet butter with nutmeg on string beans. Savory teams with limas, tarragon with carrots, basil with tomatoes. And onions boiled with whole clove and thyme would delight the taste of an epicure!

With these flavor tricks to add zest to his meals—and a glass of beer*, at your discretion, for a morale boost—your patient is more likely to follow his diet. And your treatment will have a better chance to show its effectiveness.



United States Brewers Foundation

Beer—America's Beverage of Moderation

*Sodium: 7 mg./100 gm., 17 mg./8 oz. glass
(Average of American Beers)

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535 Fifth Avenue, New York 17, N. Y.



Leave It to Univac!

By Thomas Owens

Your bookkeeping, billing, and collecting can now be turned over to an electronic brain, it says here. You doubt it? This writer saw it happen

"In the doctor's office of tomorrow, the secretary won't do bookkeeping, mail statements, or send collection letters. All these tasks—and more, besides—will be handled at a central location by high-speed data-processing machines. They'll operate under the guidance of Univac, the fabulous electronic brain."

That's the prediction of Paul H. Mallory, a former Houston (Tex.) investment banker. I heard him make it when I attended the first full-dress demonstration of the Mallory Medical Factor System in action. Paul Mallory invented the system, and he's counting on it to make his prediction come true.

Just what is the Mallory Medical Factor System? Is it a practical one for physicians? These questions were in my mind as I walked into the modern, Washington, D.C., building of Remington Rand (Univac's owner) and presented my engraved invitation.

I found myself among a dozen or so invited guests. Each of us was given a fourteen-page brochure and ten minutes to read it. Then we were ushered into

LEAVE IT TO UNIVAC!

a heavily carpeted demonstration chamber, where a half-dozen giant electronic machines stood at attention.

No Weakling, He

Mallory himself greeted us. He wasn't, as I'd expected, an ascetic-looking scientist. He was a big 200-pounder, wearing a flamboyant silk tie embroidered with a Texas-longhorn steerhead.

I winced at his viselike handshake, and his heavy laugh rumbled out. "You'd never believe I was a 110-pound sack of

skin and bones just a few years ago," he told me.

I must have looked my astonishment, because he continued: "It's a fact. I spent months in the hospital. Though up this whole medical factoring system while lying in bed. Strange ailment—a fungous growth on the lungs, with T1 of the fungus. But the old lung are O.K. now." He pounded his sternum vigorously.

Then we got down to business.

"From what I've read in the brochure," said one of the

because anemia complicates
so many clinical conditions

TRINSICON

(Hematinic Concentrate with Intrinsic Factor, Lilly)

serves a vital function in total therapy

Potent • Convenient • Economical

2 a day for all treatable anemias

In bottles of 60 and 500 pulvules,
at pharmacies everywhere.



619011

"Functional vomiting

should be carefully distinguished from organic vomiting. Grave consequences may follow if evidences of organic derangement . . . are masked by treatment designed to control vomiting alone."¹

SAFE

Safety First | in emesis therapy

Prescribe

EMETROL®

(Phosphorated Carbohydrate Solution)

First

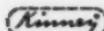
SAFE

EMETROL will not suppress symptoms arising from organic etiology. It controls vomiting of functional origin quickly.

Dosage: Adults, 1 or 2 tablespoonfuls; infants and children, 1 or 2 teaspoonfuls, as often as every 15 minutes. Always administer *undiluted*, and forbid oral fluids for at least 15 minutes after each dose. Even if first dose is not retained, continue administration. If vomiting is not controlled within one or two hours, look for organic etiology. For individual dosage regimens in various indications, please send for literature:

1. Bradley, J. E.: *Mod. Med.* 20:71, No. 3, 1952.

SAFE



KINNEY & COMPANY, INC. Columbus, Indiana

in those intranasal disorders

*where thick mucopurulent discharge indicates
there is secondary bacterial infection, prescribe*



'Trisocort' SprayPak is the intranasal preparation which provides:*

- (a) *Hydrocortisone*—the most effective intranasal anti-inflammatory agent: to reduce inflammation, edema, and engorgement.
- (b) *3 antibiotics*—gramicidin, polymyxin and neomycin: to neutralize both gram-positive and gram-negative bacteria.
- (c) *2 decongestants*—phenylephrine hydrochloride and Paredrine† Hydrobromide: to assure both rapid and prolonged decongestion.

Smith, Kline & French Laboratories, Philadelphia 1

*Trademark

†T.M. Reg. U.S. Pat. Off. for hydroxyamphetamine hydrobromide, S.K.F.

LEAVE IT TO UNIVAC!

guests, "your plan is this: A number of doctors in each area would organize a special corporation. They'd set up a central business office, where all their bookkeeping, billing, and collecting would be handled by electronic machines leased from Remington Rand.

"Each doctor would pay a service charge to the local office. And the office itself would be

obliged to pay a monthly fee to the national Mallory headquarters. Correct?"

Push-Button Payments

"Correct," said our host. "But your local office would perform other services, too. It would act as a credit-information bureau for its member-doctors. And it would also make arrangements for those patients who wanted



"Yells for something every time he sees me—probably going to grow up to be a doctor!"

CONSTIPATION



zilatone® TABLETS

gentle therapy with a rational combination of bile salts, mild laxatives, digestants.

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in boxes of 20, 40 and 80 tablets, each tablet sealed in sanitary tape. Samples on request.

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CONSTIPATION



zilatone® TABLETS

LEAVE IT TO UNIVAC!

to settle their bills in installments.

"The doctor would merely have to supply the center with a daily list of patients and fees. In return, he'd get a monthly check for the accounts collected in his name."

"What about patients covered by health insurance?" I asked.

Mallory beamed. "Your central office would be set up to handle such matters," he said. "They'd collect from insurance companies as well as from individual patients."

The Morning List

Then he launched into a detailed explanation of how the central office would operate. Here, in brief, is the system:

help your heart fund



help your heart

Only 1
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U.S. REG.

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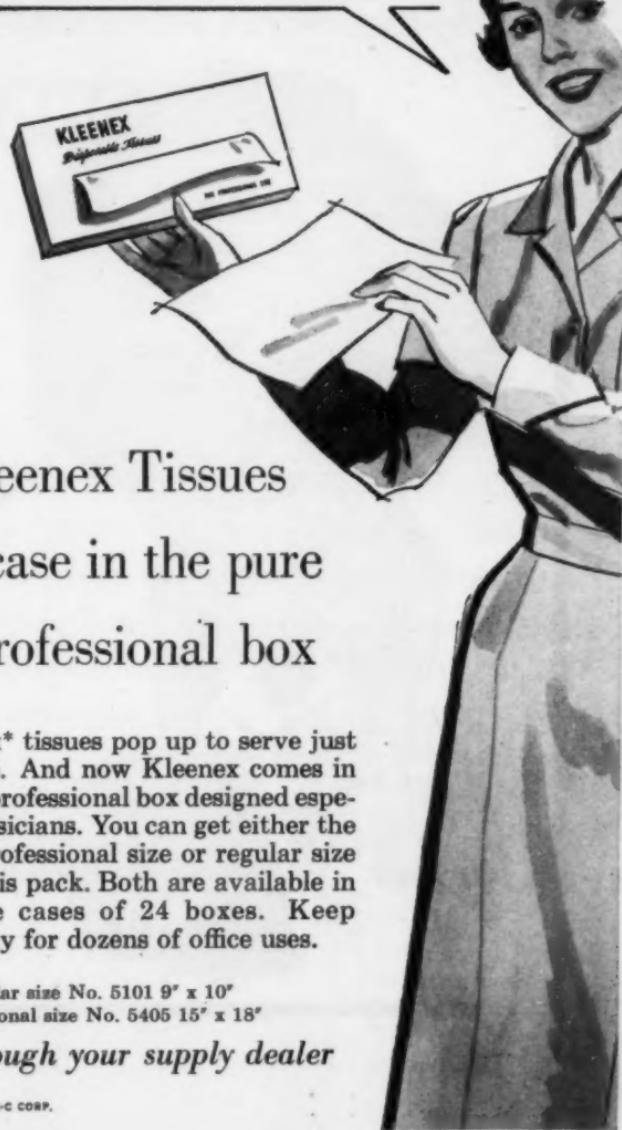
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**NO FUMBLING FOR TISSUES WITH
THE KLEENEX POP-UP BOX**



**Buy Kleenex Tissues
by the case in the pure
white professional box**

Only Kleenex* tissues pop up to serve just one at a time. And now Kleenex comes in a pure white professional box designed especially for physicians. You can get either the extra large professional size or regular size Kleenex in this pack. Both are available in easy-to-store cases of 24 boxes. Keep Kleenex handy for dozens of office uses.

Regular size No. 5101 9" x 10"
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alw

Consider the Advantages of

ANACIN

for your ARTHRITIC PATIENTS

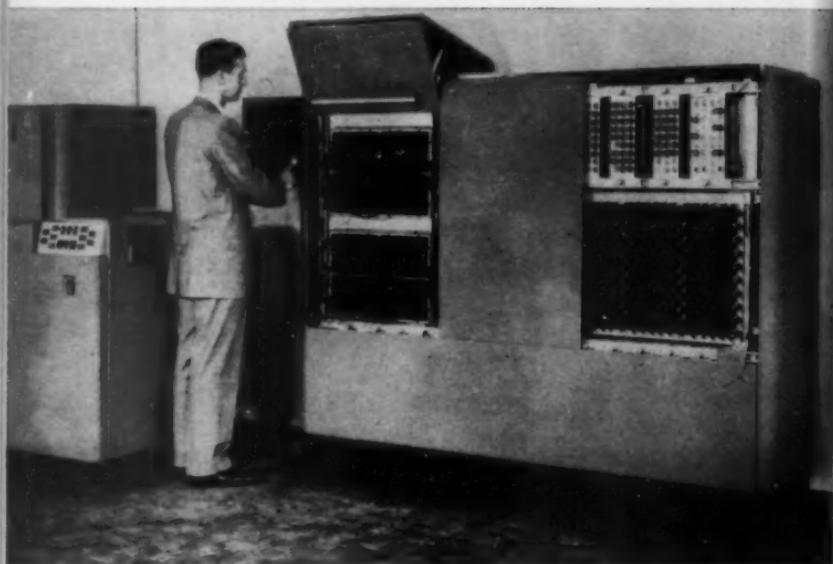
Anacin exercises prompt, efficient, and safe analgesia in relieving the ordinary aches and pains of arthritis. This skillfully compounded formula affords prolonged analgesia and is exceptionally well tolerated. Anacin can't upset the stomach. For years Anacin has enjoyed wide professional acceptance. You can depend upon Anacin Tablets for the non-narcotic and effective intervention of pain. Available at all drugstores and hospital pharmacies.

always

ANACIN

WHITEHALL PHARMACEUTICAL COMPANY, NEW YORK, N. Y.

LEAVE IT TO UNIVAC!



ELECTRONIC BRAIN—Univac 120—is part of a central bookkeeping system that has been designed to reduce doctors' billing to a push-button operation.

Each morning, the doctor's secretary sends the central office a list of the preceding day's patients. She lists each fee charged and each patient's "factor number"—which is never changed, once it has been assigned.

A clerk at the central office records all such information (plus the doctor's code number) on punch cards—one per patient. Once they've been

punched, the cards are merely stacked. No time-consuming filing is necessary.

At billing time, the machines take over. All the punched cards in the central office—perhaps 50,000, representing the month's patient load for 100 doctors—are fed through Univac and five other machines at incredible speed. The last machine produces an individual statement for each patient. It



FOUR SULFAS FOR GREATER CERTAINTY

safety • rapid action • broadest antibacterial spectrum

DELTAMIDE®

THE PREFERRED QUADRI-SULFA MIXTURE

Deltamide combines four sulfas for a better therapeutic effect and remarkable freedom from toxicity. Deltamide assures:

- effective blood levels in most patients within an hour
- increased solubility in the urine ● low incidence of sensitization
- broadest spectrum of antibacterial activity

Each Deltamide tablet or 5 cc. teaspoonful of good-tasting suspension supplies:

Sulfadiazine.....	.0187 Gm.
Sulfamerazine.....	.0187 Gm.
Sulfamethazine.....	.0056 Gm.
Sulfacetamide.....	.0111 Gm.

Tablets:
Bottles of 100 and 1000.

Suspension:
4 and 16 oz. bottles.

WHEN THE SITUATION CALLS FOR SULFONAMIDES WITH PENICILLIN—

PREScribe **DELTAMIDE w/penicillin**

Each tablet or 5 cc. of the suspension also contains
250,000 units of potassium penicillin G.



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Vitamins at a
truly therapeutic
level for all
stress conditions

Theron (STUART)

Tablets:
30's and 100's
Dose:
1 tablet daily

Liquid:
4 oz. bottles
Dose:
1 teaspoonful daily

DEPENDABLE

ON
THOSE STORMY
DAYS



HVC
HAYDEN'S
VIBURNUM
COMPOUND

Antispasmodic and Sedative

HVC

Professional samples and
descriptive literature
available on request.

NEW YORK PHARMACEUTICAL CO.
BEDFORD, MASS.

prints the patient's name and address, itemizes the monthly charges, and totals them up.

Right Down the Line

"In addition," Mallory explained, "the machines turn out a monthly report for each doctor. He gets a complete list of all patients who owe him money, with the amount each has owed for the past thirty, sixty, and ninety days. He also sees the amount the central office has collected from each during the past month."

The machine that prepares this report totals the sums collected for the doctor; it subtracts the service charge; it then automatically writes a check for whatever amount the doctor has coming to him that month."

Done in a Flash

To illustrate, Mallory held up a fistful of cards representing the patients of six mythical doctors. He handed them to a girl and she punched them swiftly. Then a Remington Rand man sent the cards whizzing through the humming, clicking machines. In no time at all, the last machine had turned out a complete financial report for each of the six doctors. [MORE ▶]

New Relief from the Enigmas of Pruritus Ani

CASE - MALE, 55 YEARS

Hydrolamins Ointment, an isotonic, specially selected combination of amino acids, offers a new answer to the baffling problem of ano-genital pruritus.

Therapy is based on the observation^{1,2,3} that this non-irritating protein counteracts the protein-precipitating irritant responsible for the pruritus and is protein-sparing to perianal tissue.

FORMULA:

Hydrolamins offers an isotonic, specially selected combination of amino acids derived from lactalbumin, in a vehicle of polyethylene glycol 1500.

SUPPLIED:

1 oz. (28 Gm.) and 2.5 oz. (70 Gm.) tubes with peel-off label.



BEFORE

Rectal itch for 20 years; itching in rectal area extending across perineum to scrotum in wide area. Red scratches in perineal region. Severe erythema. Areas sensitive, painful, tender.



AFTER

Hydrolamins applied 3 times daily to whole area. No irritation developed. Itching relieved immediately, and healing was complete in three weeks.

ECLOM

PHARMACEUTICAL COMPANY CHICAGO 14, ILLINOIS

REFERENCES:

1. Bodkin, L.G.: Amino Acid Therapy for Pruritus Ani. Am. J. Surg. 62:557 (Nov.) 1951.
2. Bodkin, L.G., and Ferguson, E. A., Jr.: Successful Ointment Therapy for Pruritus Ani. Am. J. Digest. Dis. 18:59 (Feb.) 1951.
3. McGivney, J.: Recent Advances in Proctology. Texas J. Med. 47:770 (Nov.) 1951.

NOW IN BOOK FORM!

Letters to a Doctor's Secretary



In this new volume, MEDICAL ECONOMICS has assembled its complete, step-by-step course of instruction for the physician's aide. Sixteen chapters cover such topics as:

Handling patients	Case histories
Telephone technique	Bookkeeping
Medical terminology	Collections
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Bound between handsome, black laminated covers, with the title stamped in gold, this convenient pocket-size book contains 75 information-packed pages. Prepaid price: \$2.

Medical Economics, Inc. Oradell, N.J.

Please send me "Letters to a Doctor's Secretary." I enclose \$2.

(please print)

Street

City State

LEAVE IT TO UNIVAC!

"Well, folks, what do you think?" Mallory smiled broadly. A doctor at the edge of the group spoke up:

"I get out only about 200 statements a month. If there were a central office in my area, how much would it cost me to have my accounts handled this way?"

What It Costs

"Very little. The full cost to each member-doctor would be 2 per cent of his gross billings plus a flat 15 cents for each individual billing. About how much do you collect in an average month, Doctor?"

"Roughly \$1,000."

Mallory whipped out a pencil and made some calculations on the back of an envelope. There was a pause—just long enough for me to wonder why he didn't use Univac. At last Mallory stopped scribbling and announced: "It would cost you around \$50 a month."

Not for Him!

"Fifty dollars a month!" The doctor whistled. "My girl gets out our statements now in two days—and she doesn't cost \$25 a day."

Our host pointed out that the doctor's aide spent some time



announcing

THORAZINE*

25 mg. & 100 mg. SUPPOSITORIES

to control nausea and vomiting—particularly in infants and children:

1. When oral doses cannot be retained
2. When repeated injections by the physician are not practicable

and for other conditions in which rectal administration of 'Thorazine' may be desired.

**APPROXIMATE THERAPEUTIC EQUIVALENCE OF
'THORAZINE' DOSAGE FORMS**

SUPPOSITORIES	TABLETS & SYRUP	AMPULS (I.M.)
25 mg.	=	10 mg. = 5 mg. (0.2 cc.)
100 mg.	=	50 mg. = 25 mg. (1 cc.)
Approximate Ratio		
4	= 2	= 1

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off. for chlorpromazine, S. K. F.

LEAVE IT TO UNIVAC!

all through the month doing bookkeeping. Also, the doctor's \$50 a month would entitle him to other services—credit information, for example. But the doctor still looked skeptical.

At this point, questions came thick and fast. One man said he was puzzled by something that had been puzzling me, too:

Whose Money?

"According to your brochure, the doctor can make an arrangement with the central office to pay him immediately in a lump sum, even though the

patient is paying his bill in installments. That sounds fine. But where will the office get the money, if the patient hasn't paid it?"

"Suppose," the man went on, "that a central office has 1,000 doctor-members. And suppose each doctor has just one patient who wants to pay a \$100 medical bill in installments. Suppose, finally, that all the medical men want their money right off. The office will need \$100,000 to pay them. What does it do for ready cash?"

"No problem, no problem at

New **V-CILLIN,**

*...the penicillin designed specifically
for oral administration, presented in
a liquid pediatric form.*

The Lilly logo, featuring the word "Lilly" in a stylized script font inside an oval border.

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all," said Paul Mallory. "The central office could simply borrow the money, at about 1½ or 2 per cent interest." He didn't explain where you could find a bank that would offer such generous terms.

The party soon broke up into small groups. I found myself with a quartet of medical men who wanted further information about costs. A Remington Rand executive in a far corner of the room gave us what we wanted.

"You can buy the half-dozen machines needed for about

\$175,000," he said cheerfully. "Or, if you prefer, you can rent this equipment for only \$2,400 a month."

One of my companions smiled: "Quite a bit of overhead, isn't it! In addition to which, the central office would have to buy supplies and pay rent and salaries."

Fee to Mallory

"And don't forget," added another man, "that each local office would also be required to pay a percentage of gross profit as a monthly fee to the *national*

PEDIATRIC

Each 5-cc. teaspoonful provides
125 mg. (200,000 units). Usual
pediatric dose, 1 teaspoonful q.
6 h. If used for adults, 1 teaspoon-
ful every four hours. May be
given without regard to meals.



SUPPLIED: In bottles of 80 cc. [16 doses].

Mallory system. The brochure says Mr. Mallory's organization would expect to get five mills per dollar of profit each month. That's one-half of 1 per cent. He figures that if your local office collected \$100,000 a month, it would owe the national office about \$540 a year.

"That adds something to your overhead. And meanwhile, I wonder what sort of reaction my patients would have to a Univac-type aide . . ."

All at once, it occurred to a couple of us that we could use a drink. But there were no re-

freshments in sight. Since it seemed clear that only Univac would get properly oiled, I took a last look at the electronic marvels and left.

Back to Earth

Passing from the demonstration chamber into the front office, I felt as if I were stepping from a dream into reality. There sat a girl pecking away at a standard office typewriter.

I didn't peek, but I rather hoped she was getting out Remington Rand's monthly statements.

END

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of **Lederle** quality



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VI-MAGNA*
MULTIVITAMINS

Capsules Sealed, dry-filled, easy to swallow. All essential vitamins including Folic Acid and B₁₂.

Syrup Orange-lemon flavor; no fishy taste or odor. Can be mixed with fruit juice, milk or milk formula. Nine essential vitamins, including B₁₂.

Granules Orange-flavored. Can be dissolved in liquids or mixed with solid food. All essential vitamins, including Folic Acid and B₁₂.

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*to keep
baby's skin clear,
smooth, supple,
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Tubes of 1 oz., 2 oz., 4 oz., and 1 lb. jars.

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70 Ship Street • Providence 2, R. I.

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4. Turell, R.: New York St. J. M. 50:2282, 1950.

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Local Youngsters In Child's Dream Birthday Party

Sharing the same birthday, seven children from the Magnolia Hollow section were yesterday given a joint party by Mrs. James Robb, Jr.

Dressed dolls, Davy Crockett caps, and games vied with refreshments for the children's attention.

"Each child," said Mrs. Robb, "was given ham salad, sandwiches, potato salad and a choice of pastries."

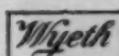
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Dihydrostreptomycin Sulfate and Pectin with Kaolin in Alumina Gel



Philadelphia 1, Pa.



Let's Stop Paying the I.L.O. To Socialize Medicine

By Louis H. Bauer, M.D.

The International Labor Organization menaces free U.S. medicine, warns this doctor. Yet the I.L.O. may be given more of your tax dollars

There's a bill before this session of Congress called Senate Joint Resolution No. 97 that means trouble for the medical profession. You won't find the bill on the usual lists of pending medical legislation. Yet it calls for United States financing of a short cut to socialized medicine in this country.

S. J. Res. 97 seeks to raise the U.S. contribution to the International Labor Organization from \$1½ million to \$3 million a year. Since the U.S. pays 25 per cent of the I.L.O.'s total budget, such a boost in the American share would automatically lift I.L.O. spending from \$7 million to \$12 million a year.

This means that the I.L.O. would be able to do nearly twice as much as it's now doing to promote its announced aims. One such aim is to internation-

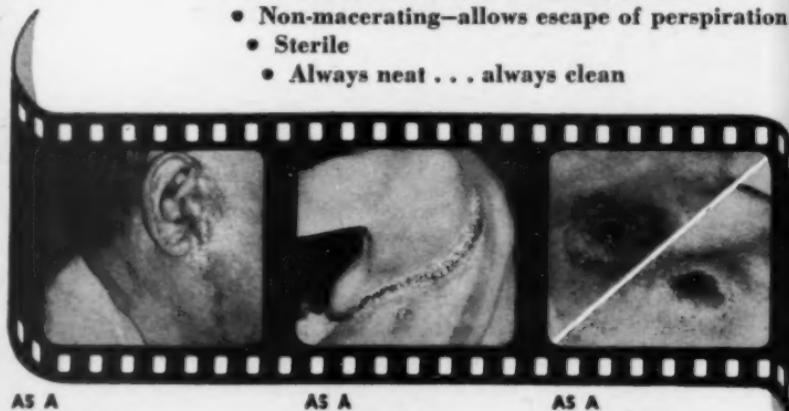
THE AUTHOR, a former president of the A.M.A., is secretary general of the World Medical Association, a nongovernmental organization representing practicing physicians in fifty-two countries. To keep in touch with them, he has visited Europe eighteen times in the last eight years and has twice traveled around the world.

*The modern approach to wound dressing
in Hospital, Office or Industrial Clinic*

AEROPLAST® PLASTIC SPRAY-ON DRESSING

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- Non-adherent—to raw wound surfaces
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- Always neat . . . always clean



AS A BANDAGE*

Laceration (shown above)
Film dressing conforms to
hard-to-bandage sites

Scalp wounds
Abrasions and Burns
Skin eruptions

*If hemostasis is complete, use Aeroplast alone. If incomplete, apply one coat of Aeroplast, a layer of gauze, then spray gauze and surrounding skin area with Aeroplast.

AS A SURGICAL DRESSING

Thoracotomy (shown above)
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Herniorrhaphy
Major burns
Vein ligations
Mastectomy
Decubitus ulcers

AS A PROTECTIVE COATING

Excoriation (shown above)
Area around ileostomy
cleared in 24 hours
To prevent excoriation
To control dermatologic
distress, e.g., itching or
burning as in sunburn or
poison ivy
Under skinlight casts
Episiotomy



easy to apply

1. Spray a light film onto aseptic dry wound from a distance of 6 to 12 in. Cover adjacent area of intact skin to provide anchorage. Hemostasis should be complete. May be applied over sutures.
2. Allow film to dry for 30 seconds. (sufficient time for the acetone solvent to evaporate)
3. Repeat "spray and let dry" procedure (steps 1 and 2 above) two more times.



Supplied in 6 oz.
aerosol-type dispenser.
Available through your
surgical supply dealer
or prescription pharmacy.

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Write AEROPLAST CORPORATION
429 Dellrose Avenue, Dayton 3, Ohio

1. Vibesate (Aeroplast) — New and Nonofficial Remedies, 1955, p. 541.

LET'S STOP PAYING THE I.L.O.

alize sickness insurance and to impose government medical care on the organization's seventy member nations.

I've been observing the workings of the I.L.O. for many years, and I've concluded that it's *the greatest threat in the world to free and independent doctors like you and me*. Furthermore, I've concluded that socialized medicine is only *part* of its program. Its over-all goal

is complete socialization of every country in the world.

For a time after its creation in 1919 under the League of Nations, the I.L.O. did some good work in improving the status of the working man. But since World War II, under the United Nations, the organization has dedicated itself completely to the socialist ideology.

And since Russia became a member in 1954, it seems clear



"Yes, I can give you some advice, Son: Take your undergraduate work where you'll be going to medical school. You'll then be on only one alumni list for contributions."

PAYING THE I.L.O.

that the trend toward socialism won't slow down. Already the Iron Curtain countries in the I.L.O. can outvote the U.S. by 32 to 4 on any question raised.

The I.L.O. threat to the practice of medicine as we know it can be met if we doctors understand what's going on in the United Nations and its specialized agencies. That's why I'd like to tell you what I've learned from firsthand observation.

Two Ways to Socialize

First, let's take a look at how the I.L.O. could force socialized medicine on this country. It could do this in two ways: *directly*, through international treaty, and *indirectly*, through political pressure and propaganda.

1. *The direct approach: American physicians could find themselves under Government control if the Senate ratified the I.L.O. treaty on social security standards.*

Had the Senate approved the I.L.O.'s 1952 treaty on minimum standards of social security, the U.S. Government would now be committed to provide G.P. and specialist services, plus hospitalization and drugs, to "not less than 50 per cent of all

Rx Information **Kolantyl** Gel and Tablets

Action:

Bentyl® content affords spasmolytic and parasympathetic-depressant actions without the side effects of atropine.

Rapid, Prolonged Antacid Relief... Balanced antacids—no laxation—no constipation

Proven Demulcent Action...Helps protect normal cells, encourages cellular repair

Anti-enzyme Action...Necrotic pepsin and lysozyme action checked

Composition:

Each 10 cc. of KOLANTYL Gel or each KOLANTYL tablet contains: Bentyl Hydrochloride..... 5 mg. Aluminum

Hydroxide Gel..... 400 mg. Magnesium Oxide 300 mg. Sodium Lauryl Sulfate..... 25 mg. Methylcellulose 100 mg.

Dosage:

Gel—2 to 4 teaspoonfuls every three hours, or as needed. Tablets—2 tablets (chewed for more rapid action) every three hours, or as needed.

Supplied:

Gel—12 oz. bottles. Tablets—bottles of 100 and 1,000.

1. Johnston, R.L.: J. Indiana St. M.A. 46:869, 1953. 2. McHardy, G., and Browne, D.: Southern M.J. 45:1139, 1952.

THE WM. S. MERRELL COMPANY
New York • CINCINNATI • St. Thomas, Ontario

*Merrell's distinctive antispasmodic that is more effective than atropine—free from side effects of atropine.²

T.M. "BENTYL", KOLANTYL®

Kolantyl + diet



= sound ulcer therapy

provides prolonged relief of ulcer pain.¹

Kolantyl: 1. Neutralizes acid, 2. Inhibits pepsin, 3. Relieves hypermotility and spasm through musculotropic action, 4. Relieves spasm through neurotropic action, 5. Forms protecting demulcent, 6. Inhibits lysozyme.

This combination of ulcer-combating ingredients in pleasant-tasting KOLANTYL Gel, or convenient tablets, makes rational its use as the medication of choice in peptic ulcer therapy.



Pioneer in Medicine for Over 125 Years

Capillary Integrity in Vascular



26 year old male. Severely beaten about face and head. Multiple contusions and marked edema about face and head, and epistaxis. Massive subconjunctival hemorrhages in both eyes. Both eyelids markedly edematous.

Injections of trypsin (2.5 mg.) were given every 12 hours. Decrease of edema after 18 hours. After 36 hours, both eyes were open. 96 hours after trypsin administration, edema and hemorrhage resorbed; contusions healed; treatment completed.

Impairment of local circulation in edematous vascular inflammatory and traumatic conditions hampers the physiologic restorative reaction.¹ Inflammatory edema is due to increased capillary pressure, dilatation of the vessels and local slowing of the circulation.²

Early administration of direct acting anti-edema, anti-inflammatory

the first parenteral proteolytic enzyme

PARENZYME®

INTRAMUSCULAR TRYPSIN

results in the breakdown of the "mechanical" barrier walling off these areas of local stress.² Every physiological restorative process present in the blood is made available for resorption of edema and necrotized tissue and speeding the healing process.^{1,3,4}

Indications: Cardinal indication for Parenzyme is acute inflammation. Slow-healing wounds, bruises, contusions, black eyes; phlebitis, thrombophlebitis, phlebothrombosis; decubitus, diabetic, varicose skin ulcers; iritis, iridocyclitis, chorioretinitis.

Dosage: 2.5 mg. (0.5 ml.) intraglutaneously q. 6 h. until improvement results; q. 12 h. thereafter.

Recommended Method of Injection: very slowly intraglutaneously.

Supplied: 5 ml. multiple-dose vials (5 mg. trypsin/ml.).

The film, Clinical Enzymology, is available for showing at all medical meetings upon request. And be sure to watch for the Medical Audiographs, a series of recorded clinical discussions.



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inflammation and Traumatic Conditions

The status of the involved capillaries will have an important influence on any inflammatory process and on the extent and rapidity of recovery.

HESPER-C



restores and maintains capillary integrity and aids in preventing spread of capillary deterioration.⁵ In the final analysis, the achievement of tissue homeostasis, the primary function of the circulation, is dependent upon the integrity of the terminal vascular bed. Prevention of capillary fault, and restoration and maintenance of normal capillary permeability will help prevent hemorrhage and loss of essential tissue nutrients and metabolites needed for repair of injured tissue.⁶ The principle of improving capillary status with Hesper-C to minimize decidual bleeding in habitual aborters has been very successfully applied to the problem of fetal salvage.^{7,8,9}



Red blood cells escaping from a capillary under abnormal conditions of capillary fragility. Such alterations in the permeability of the uterine capillaries in pregnancy lead to bleeding into the decidua basalis.

The decidua then splits; a decidual hematoma is formed which leads to premature separation of the normally implanted placenta.

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Addition of Hesper-C to current therapy made the difference in reversing 95% fetal wastage in 100 patients to 95% fetal salvage.⁹ Capillary integrity is a determinant in cellular or body resistance to stress.¹⁰

BY OR ON PRESCRIPTION ONLY.

Indications: Complimentary action with Hesper-C will more quickly restore capillary function in inflammatory areas while maintaining general capillary integrity. It is further indicated in: upper respiratory infection, cardio- and cerebrovascular disease, habitual abortion and fetal salvage, purpuras, epistaxis, diabetes and diabetic retinopathy, hematuria, hypertension and preventive geriatrics. Dosage: No less than 6 capsules or teaspoonsfuls (5 ml.) daily. Supplied: Hesper-C capsules in bottles of 100 and 1000, liquid in bottles of 4 oz. and 12 oz. Each capsule and each teaspoonful of liquid provide hesperidin concentrate, 100 mg., and ascorbic acid, 100 mg.

PRODUCTS OF ORIGINAL RESEARCH
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**For
OBESITY
CONTROL**

AIDS TACROS IN
Amvicel
(STUART)

Dose: 1 capsule 16 hours before meals.
Bottles of 100 capsules.

THUMBSUCKING

since infancy caused this 4 year old's malocclusion.



THUM
TRADE MARK

THUM broke the habit and teeth returned to normal position in 9 months.



**THUM DISCOURSES
NAIL BITING TOO**

Available from your drug store and surgical dealer for over 20 years.

PAYING THE I.L.O.

residents." At the same time, voluntary health insurance plans would be allowed to function only under direct governmental supervision.

Fortunately, the Senate didn't act on the '52 treaty. One good reason why it didn't: The nation's physicians effectively pointed out its dangers.

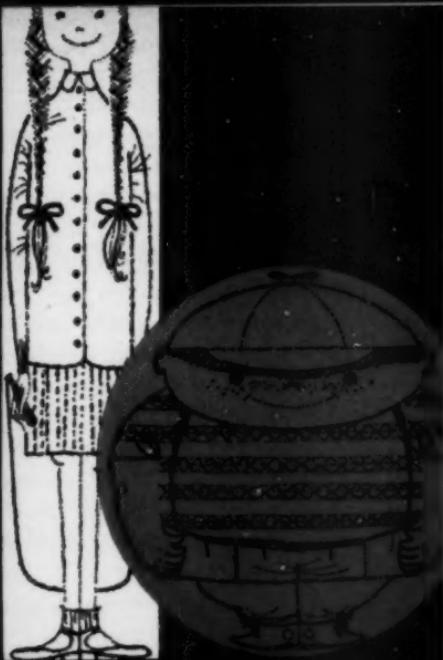
But there still remains a possibility that the I.L.O. plans for government medicine could find their way directly into our national statutes. Seven I.L.O. treaties have already been approved by the Senate and signed into law by the President. (These deal mostly with conditions of maritime employment, and I'm happy to say they're not socialistic.)

More Immediate Threat

2. The indirect approach. American doctors could be caught in a socialistic net through political pressure and propaganda dignified by I.L.O. endorsement.

Although the U.S. didn't accept the I.L.O.'s social security standards in treaty form, propaganda points were scored by the champions of "welfare state" medicine. The I.L.O. itself adopted the treaty by an impressive vote of 123 to 32 (with

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children come in all sizes and widths.

And, with very few exceptions,
so do Stride Rites!

Stride Rites' extensive size and
style range... and exact construction
enables children to be most accurately
fitted, whether they are short and
chubby or long and lanky.

What's more, Stride Rites are made of
quality leathers, moulded over tested last
to hold their shape a long, long time
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You can rely on Stride Rites for your
young patients... from the first
walking year through the sub-teens.
Most doctors who know these
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twenty-two abstentions). Many of the member countries have since accepted it as law.

As the vote indicates, the organization in its very make-up stands 3 to 1 against free enterprise. Each country has two Government delegates, one labor delegate, and one employer (or management) delegate. And nine times out of ten, the U.S. Government representatives—like those of other countries—range themselves on the side of labor against management.

Thus, the American delega-

tion voted 3 to 1 for the government medical care clause in the social security treaty.

As a member of the I.L.O. (since 1934), the U.S. is required to submit regular reports of the steps it has taken to carry out I.L.O. treaties. So when our representatives report that we're not complying with what are described as minimum standards of welfare, imagine what grist this provides for the Russian propaganda mill!

What's worse, our representatives in Washington are sometimes impressed by I.L.O. pro-

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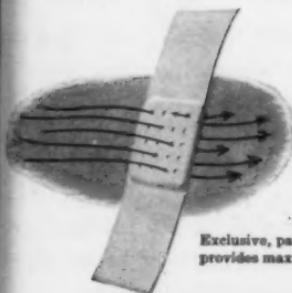
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posals. For proof, consider H.R. 7225, the Social Security Amendments of 1955. This bill, now before the Senate, was approved in the House by an overwhelming 372 to 31. Many doctors are greatly disturbed by one section of it, which calls for Government benefits for the disabled at age 50.

Well, the I.L.O. social security treaty includes exactly the same provision. And note this: Much of the language of H.R. 7225 is *identical* with that of the I.L.O. document!

The international body, for example, defines "invalidity" (or disability) as the "inability to engage in any gainful activity." The House bill defines it as the "inability to engage in any *substantial* gainful activity." That's a change of only one word.

The Word to Watch

In the future, if you spot the word "invalidity" in a piece of national legislation, look twice. It may well be the fingerprint of the I.L.O.

Now let me tell you what some of us in the medical profession are trying to do about this unhappy situation:

The World Medical Association carries the ball on behalf

LET'S STOP PAYING THE I.L.O.

of the practicing physician. It keeps its eye on the I.L.O., the International Social Security Association, the World Health Organization, and similar groups. It works hard for *you*—and it has plenty of obstacles in its way.

No Advice Wanted

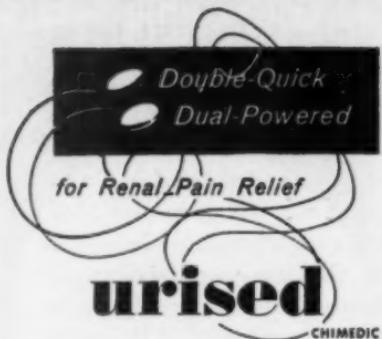
For example, when the I.L.O. was drafting the social security treaty in 1952, the World Medical Association sought to pre-

sent the views of doctors from forty-six countries. No one in the I.L.O. asked for our advice, but we decided to offer it anyway. I was one of four W.M.A. officers who went to Geneva to ask the labor organization to distribute to the delegates a W.M.A. statement on the medical aspects of social security.

At I.L.O. headquarters, my colleagues and I were given a polite runaround. The director



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general, David A. Morse—former U.S. National Labor Relations Board attorney and one-time Under Secretary of Labor—wasn't available. His deputy told us we'd have to get authorization for distributing our statement from the chairman of the I.L.O. conference committee on social security. Only there was one catch: The committee chairman wouldn't even be appointed until the conference got under way.

Well, we managed to get the



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0.05% and 0.1%, 15 ml. plastic squeeze bottles.
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statement into the hands of some delegates. But we did it only by distributing copies ourselves through the W.M.A. liaison officer in Geneva.

Later, Mr. Morse came to me to tell me how sorry he was. By that time, the I.L.O. treaty had already been adopted.

You're a Technician

The truth is, the I.L.O. tends to look on doctors in general as technicians rather than as the men best qualified to give authoritative medical opinions. Instead of setting an example

of good medical practice at the international level, the I.L.O. seems to be moving in the opposite direction. Some illustrations of what I mean:

¶ The director of I.L.O. activities in industrial medicine is a safety engineer with no medical qualifications whatever. Yet the M.D.s employed by the organization take orders from this man even in strictly medical matters.

¶ William L. McGrath, U.S. employer-delegate to the I.L.O., was shocked at the absence of medical opinion at a meeting of

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Erythromycin in treatment of pyoderma

8/12/55

DISCHARGE SUMMARY

Patient, white female, age 39, entered hospital with a diagnosis of lymphoma, proved to be lymphosarcoma by biopsy.

Initially she was treated by X-ray radiation, adrenal cortical hormone and an antinauseant. During this regimen she developed a generalized rash which became infected. This was a drug reaction with infection due either to (1) scratching or (2) a low WBC count due to radiation. A number of boil-like lesions appeared over the body.

On 8/4 penicillin was started in a dosage of 600,000 units daily. Penicillin was continued for six days during which time the pyoderma became worse.

Aspirated material from the lesions yielded hem. S. aureus, coag. + and the following sensitivities were obtained: penicillin, more than 10 units; erythromycin, 10 mcg.; tetracycline, 50 mcg. When these results became available penicillin was discontinued.

On 8/9, erythromycin was started in a dosage of 200 mgm. q. i. d. Marked improvement was noted very soon and by 8/12 almost complete healing of all lesions had occurred. Patient was afebrile throughout.

Final Diagnosis: (1) lymphosarcoma (2) secondary pyoderma due to hemolytic Staphylococcus aureus.

Result: complete healing of secondary pyoderma with erythromycin.

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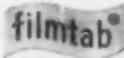


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the Committee on Maternity Protection that he attended last year. He says: "At times I couldn't believe my ears. In that committee, [lay] representatives from countries all over the world spent an entire half-day debating whether or not an international law should contain a provision to the effect that a mother should nurse her baby for one hour during the working day or for two half-hour nursing periods . . ."

¶ The only advice the I.L.O. ever sought on the medical section of its social security treaty

was from the World Health Organization. The W.H.O. named a special committee that included not a single practicing physician. The committee's report recommended full-time, salaried medical service in every country because "the fee-for-service system exposes the physician to the temptation to care for a patient who should be sent to a specialist or an institution."

What can we doctors do to make sure that socialized medicine isn't thrust upon us through international legislative trea-

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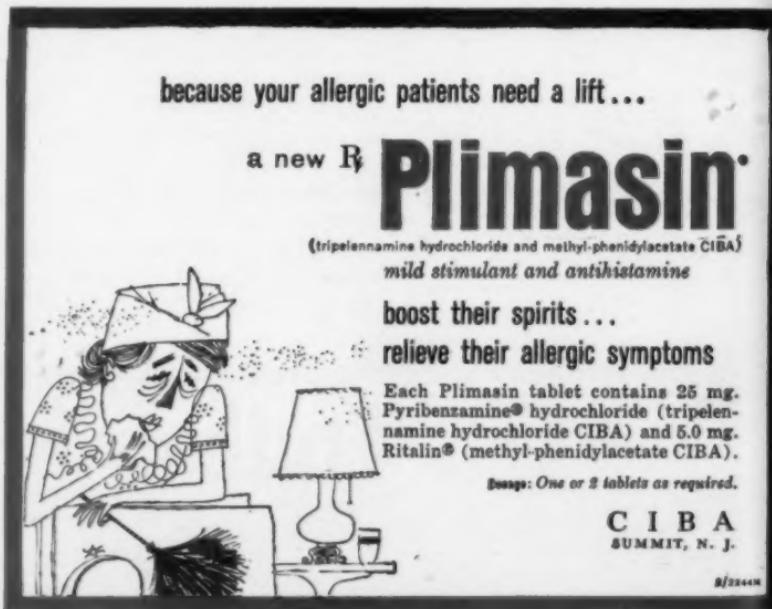
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ties? I have two suggestions:

1. We can keep ourselves informed of what's happening to medicine in the international field.

Where to Turn

The best available source of such information: the periodic reports of the World Medical Association. The United States Supporting Committee for the W.M.A. offers membership to county societies and to individual physicians, as well as to laymen and lay organizations.

2. We can alert our repre-

sentatives in Congress to the danger.

I'm confident that if we in the profession bring the right kind of pressure to bear on our elected representatives, we can make them see what's behind the I.L.O.'s sweeping generalities about "better medical care for all."

So don't hesitate to let your Congressmen know how you feel about medical care schemes like the I.L.O.'s. And since you and I must foot the bill, let's help defeat the proposal known as S. J. Res. 97.

END

"Combinations . . . produce fewer side effects . . ."

Waldron, J.M., et al.: Am. J. M. Sc. 230:551 (November) 1955

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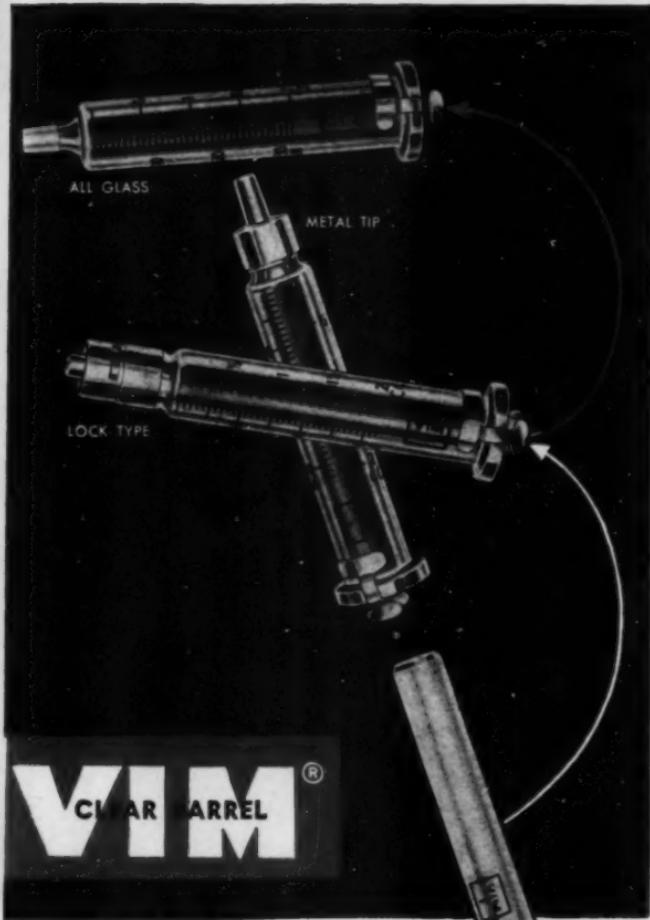
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REFERENCE: 1. Silcox, L. E., *A.M.A. Arch. Otolaryng.* 60:431, Oct. 1954.

Licensure: the Best Way To Clean Up the Mess

By Greer Williams

Authorize the National Board of Medical Examiners to act as a voluntary agent for the various state boards in testing doctors, this writer suggests

The easiest licensing examination you can take is usually that of the state where you graduated from medical school. Except in Texas, Illinois, New York, Vermont, and Oregon, your chance of failing it is close to zero.

But if you ever want to practice in another state, you'll be much better off if you're a diplomate of the National Board of Medical Examiners.

As such, you come nearest to being the free American medical citizen that every doctor would like to be. You have passed an examination that one state board secretary describes as "more difficult and searching than any state's."

Yet some states fail more examinees than does the National Board!

[MORE ▶]

THIS ARTICLE is the third and last of a series. The first, published in January, described the current shambles of medical practice acts in the U.S. The second presented some possible reforms, none of which seemed as promising as the solution discussed here.

CLEAN UP THE LICENSURE MESS

Here is an examining system that is completely voluntary, long-established, widely respected, smooth-operating, manifestly impartial. Those who pass the examination are certified as qualified to be licensed anywhere in the United States or its territories.

30,000 Have Passed

The National Board's sole purpose is to give a good examination and to serve its diplomats in their licensing adventures. It has no favorite sons and sets no mousetraps. (But sometimes, as you'll see, a state board *will* mousetrap the National Board diplomate.)

What is the Board's record of usefulness to doctors?

It has examined and certified 30,000 physicians since it got rolling in 1922. These men have been able to get their first license as a result. And (since the vast majority of states endorse National Board certificates) they have often been granted licenses in as many as five additional jurisdictions. Such licenses are frequently difficult or impossible to get through state-to-state reciprocity or endorsement.

Every year now, the Board certifies about 2,000 new doctors for their first license. This is about one-third of the annual crop of medical graduates. In addition, the Board annually attestates the qualifications of 1,400 older practitioners who need an additional license.

You may not have a very clear idea of the status and function of the National Board of Medical Examiners. So let's take a moment for a review of the facts:

Who Runs It?

Back in 1915, the idea for the Board was conceived by Dr. William L. Rodman, onetime A.M.A. President. Today the Board consists of thirty-nine doctor-members (twenty of them professors and six of them state-board-members). The A.M.A., the Association of American Medical Colleges, the armed forces medical departments, and the Veterans Administration are all represented on it.

Dr. Robert A. Moore of the University of Pittsburgh is National Board president. The vice president is Dr. Herman G. Weiskotten of New York, chair-

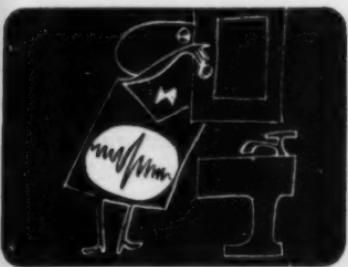
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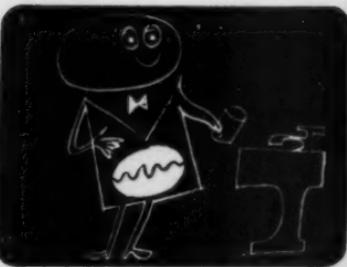
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man of the A.M.A. Council on Medical Education and Hospitals. And Dr. John P. Hubbard, a pediatrician by training, is executive secretary and treasurer. The Board has headquarters at 133 South Thirty-sixth Street, Philadelphia 4, Pa.

Seemingly, the National Board of Medical Examiners provides a ready-made answer to Osler's half-century-old plea for universal reciprocity among states. It also seems an ideal alternative to any attempt at Federal medical licensing.

The big hitch with reciproc-

ity, experts point out, is that the fifty-four jurisdictions don't have the same examination standards. Even if they did, no board could be sure that all the others were *applying* the standards so that every candidate got equal testing. On the other hand, all evidence shows that the National Board goes to painstaking lengths to achieve complete uniformity.

Here, more specifically, is how the National Board works:

It will give examinations to any graduate of an approved medical school in the United

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States or Canada. He pays a registration fee of \$5, plus \$20 each for Parts I and II of the examination and \$40 for Part III—a total of \$85.

Occasionally, an older doctor will take the examinations. But most candidates take them while their schooling is still fresh in their minds.

The Part I examination is held at medical schools in June and September. It's open to stu-

dents who have completed their first two years, or to any doctor who signs up. It tests the candidate's knowledge of the basic sciences.

For M.D.s Only

Part II is given at medical schools in April and June. The candidate must have successfully completed Part I and a four-year medical school course. This examination covers medi-



CLEAN UP THE LICENSURE MESS

cine (including psychiatry and legal medicine), surgery, obstetrics, gynecology, public health, preventive medicine, and pediatrics.

The Toughest Test

Doctors who have passed Parts I and II, and who have completed their internships, are eligible for Part III. It's conducted by subsidiary boards in thirty-three cities in late June, as well as at other announced times. This examination, says the Board, is "a clinical and practical evaluation of

the candidate's ability in observation, in diagnostic acumen, and in the principles of therapy."

In the course of seven hours, the candidate sees patients or clinical specimens representing four cases—in clinical medicine, in clinical surgery, in pediatrics, and in obstetrics-gynecology. He writes an essay on each case; and the examiners review the essay and question him.

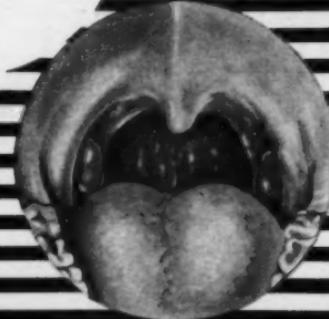
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[MORE ▶]

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Rutin	25 mg.
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Iron (as FeSO ₄)	0.5 mg.
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Phosphorus (as CaHPO ₄)	0.1 mg.
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Copper (as CuO)	0.1 mg.
Fluorine (as CaF ₂)	1 mg.
Manganese (as MnO ₂)	1 mg.
Magnesium (as MgO)	1 mg.
Potassium (as K ₂ SO ₄)	5 mg.
Zinc (as ZnO)	0.5 mg.

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more effective therapeutic agent than older corticosteroids

Three to five times as potent as oral cortisone or hydrocortisone, milligram per milligram, METICORTEN provides enhanced anti-inflammatory and antirheumatic action without the major undesirable effects associated with older corticosteroids.

Within 24 hours after administration of METICORTEN, joint pain decreases, and stiffness and local heat diminish. Improvement in functional capacity and mobility follows quickly.^{1,2} Excellent results are obtained even in patients no longer responding to cortisone or hydrocortisone.^{1,2}

And in intractable asthma, METICORTEN controls symptoms rapidly, markedly increases vital capacity, and permits patients to resume normal activities promptly.^{3,4}

Dosage and Administration

METICORTEN is available as 5 mg. scored tablets in bottles of 30 and 100. In the treatment of rheumatoid arthritis, dosage of METICORTEN begins with an average of 20 to 30 mg. (4 to 6 tablets) a day. This is gradually reduced by 2½ to 5 mg. until maintenance dosage of 5 to 20 mg. is reached. The total 24-hour dose should be divided into four parts and administered *after meals and at bedtime*. Patients may be transferred directly from hydrocortisone or cortisone to METICORTEN without difficulty.

idrthritis

*"...free of significant metabolic,
water or electrolyte disturbances."*^{**}

The higher therapeutic ratio of METICORTEN permits marked clinical benefits unaccompanied by many of the major undesirable actions characteristic of cortisone and hydrocortisone.¹⁻⁴

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PREDNISONE (metacortandracin)

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- avoids sodium and water retention
- avoids weight gain due to edema
- no excessive potassium depletion
- better relief of pain, swelling, tenderness; diminishes joint stiffness
- lowers sedimentation rate even where cortisone or hydrocortisone ceases to be effective—"cortisone escape"
- most effective in smallest dosage

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METICORTEN,^{*} brand of prednisone (metacortandracin).
T.M.

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CLEAN UP THE LICENSURE MESS

Graduates of approved medical schools don't do badly at this triple hurdle race. Not so badly, at any rate, as state board examinees do in eight different states: Florida, Texas, New York, Illinois, Arizona, Connecticut, New Hampshire, and Vermont.

The National Board's failure rate is 5.5 per cent. Some of the above-named state boards have failure rates four or five times as high. Yet few people would claim that any state board tests are stiffer than the National Board's.

A number of medical schools—among them, Harvard, Yale, Cornell, and Columbia—encourage their students to take the National Boards. In fact, most of the graduates from twenty schools take them.

Conversely, the graduates from eleven schools ignore the opportunity entirely. For the most part, these schools are state universities. Their graduates are assured of "nominal formality" licensing within the state.

Such doctors are all set as long as they're content to remain lo-

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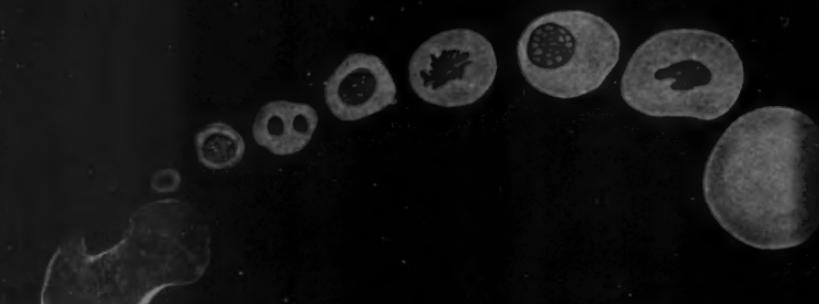
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—Gardner, F. H.: *J. Lab. & Clin. Med.* 41:56 (Jan.) 1953.

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—Holly, R. G.: *Obst. & Gynec.* 5:562 (April) 1955.

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—Hill, J. M.; LaJous, J., and Sebastian, F.J.: *Texas J. Med.* 51:686 (Oct.) 1955.

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CLEAN UP THE LICENSURE MESS

cal boys. But it's another matter if they ever want to leave home. (For examples of what they may have to contend with, see "Licensure: It's a Mess!", MEDICAL ECONOMICS, January, 1956.)

For the National Board diplomate, leaving home is a much simpler matter. When he applies for a license in another state, he merely writes to Philadelphia and asks the National Board to certify that he has passed its examinations. The Board supplies the credentials in accordance with the requirements of the state board.

What the states require varies greatly, of course. But most of them endorse the National Board's certification; and they'll issue the license without further examination or restriction.

Some states, jealous of their prerogatives, push the National Board diplomate around a little. A few others slam the door in his face. These few can't seem to swallow their resentment toward the Board.

A couple of years ago, this resentment boiled over, and the Board caught hell from several state boards.

[MORE ▶]



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CLEAN UP THE LICENSURE MESS

In 1953, the Board had reached a high-water mark of popularity: It enjoyed recognition by forty-six states, as well as by the territories. Only Florida and Texas refused to honor its examinations at that time.

Then, in 1953 and 1954, came the States' Rights Secession movement. Nebraska, Kansas, South Carolina, New Mexico, Arkansas, Georgia, Indiana, Louisiana, North Carolina, Michigan, and Pennsylvania all withdrew their recognition. Along with Florida and Texas, that made thirteen.

Why did this happen?

The charges made a rich mixture: "The National Board is

getting too big for its breeches" . . . "It's trying to set up a Federal licensing system." . . . "It's another example of creeping socialism." . . . "It has reduced its examinations to a true-and-false farce." . . . "It's a back door through which D.P. doctors can pour into our state."

The hard nut of fact was that the National Board had changed its testing techniques. It had scrapped its essay questions in Parts I and II and had introduced the multiple-choice type.

This gave the National Board's critics their opening. Pennsylvania said its law required all candidates to take a *written* examination. If all a candidate



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Potassium guaiacolsulfonate	8 gr.
Menthol	q.s.
Alcohol	5%

Supplied in 16-ounce and 1-gallon bottles.

DOSAGE: Every three or four hours—adults, 1 to 2 teaspoonfuls; children, ½ to 1 teaspoonful.

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Antibacterial "irrigation from within" successful in acute and chronic urinary tract infections

Rapid local concentration important feature of therapy

Antibacterial "irrigation from within" effectively combats pathogenic organisms in the urinary tract.

Ninety-six per cent of acute cases, and 84 per cent of chronic cases, of various urinary infections are reported cured or improved with this type of oral chemotherapy. The drug used was "Thiosulfil," single sulfonamide specifically designed for urinary tract infections.

The prevalence of infections of the urinary tract is second only to those of the respiratory system.¹ Many disease causing organisms are normally present without symptoms. In studying 356 preoperative patients, Creevy and Feeney² found pathogenic organisms in the urinary tract in 71 per cent of cases.

To create an ideal culture medium for this ever present pathogenic flora, it requires little more than an insignificant initial injury; this may be due to instrumentation in cystoscopy or catheterization, and particularly to urinary stasis.

The misuse of antibiotics has given rise to criticism by numerous clinicians. Eradication of bacterial antagonists by broad spec-

trum antibiotics may result in serious generalized infections.^{3,4} In light of this, the physician may question whether the systemic action of the antibiotics is necessary or even desirable when there is no bacteremia and the infection is limited to the urinary tract.

The site of infection is the only territory in which the invading bacteria can be fought. This requires a specific drug which should meet all these criteria:

- (a) a good bacteriostatic index within the spectrum of urinary tract pathogenic organisms;
- (b) minimal systemic effects;
- (c) high solubility (within the range of urinary tract pH) with fast excretion producing high active drug levels in the urine without danger of crystallization;
- (d) low acetylation (making the drug available in its free, active form).

It is generally accepted that, in infections of the urinary tract, sulfonamides are usually at least as effective as the antibiotics and are active against a wider variety of organisms than most antibiotics.

(Continued)

Treatment of Urinary Tract Infections

(Continued)

Goodhope⁵ found that "Thiosulfil" (sulfamethizole) is rapidly absorbed (a 2 Gm. oral dose produces a blood level of 6 mg. per hundred cubic centimeters in 2 hours), that 90-95 per cent is maintained in the free form, that it is rapidly excreted and that it is highly soluble within a wide pH range.

Thus, "Thiosulfil" is rapidly concentrated where urine is formed and, acting as a virtual "irrigation from within," it travels along the urinary channels inhibiting bacterial activity all along the way.

Bourque and Joyal⁶ reported that "Thiosulfil" was remarkably well tolerated . . ." and produced good results in patients with cystitis. Hughes and associates⁷ found it effective in 96 per cent of acute cases and 84 per cent of chronic cases including pyelonephritis, cystitis and urethritis. Barnes⁸ used "Thiosulfil" in various types of chronic urinary tract infections (many of which were refractory or intolerant to other drugs) and obtained favorable results in 75 per cent. He noted in particular that "Thiosulfil" is well tolerated.

Recommended Dosage: The average dosage of "Thiosulfil" for adults is 0.5 Gm. five or six times daily. The pediatric dosage is scheduled on an average basis of 30 to 45 mg. per pound of body weight per day.

It is usually unnecessary to force fluids. In fact, limiting intake aids in achieving greater concentration with more sustained action. If voiding occurs during the night, an extra half-dose should be given.

"Thiosulfil" is available in 0.25 Gm. scored tablets (bottles of 100 and 1,000), and in suspension which yields 0.25 Gm. of "Thiosulfil" per 5 cc. (bottles of 4 and 16 fluidounces).

Even when urinary retention and severe uremia complicated the infection, "Thiosulfil" was given with good results. Goodhope⁵ in summing up his experiences said: "I do not hesitate to give 'Thiosulfil' to a patient in whom there is a history of sensitivity to sulfa drugs—I believe that 'Thiosulfil' deserves wide clinical acceptance."

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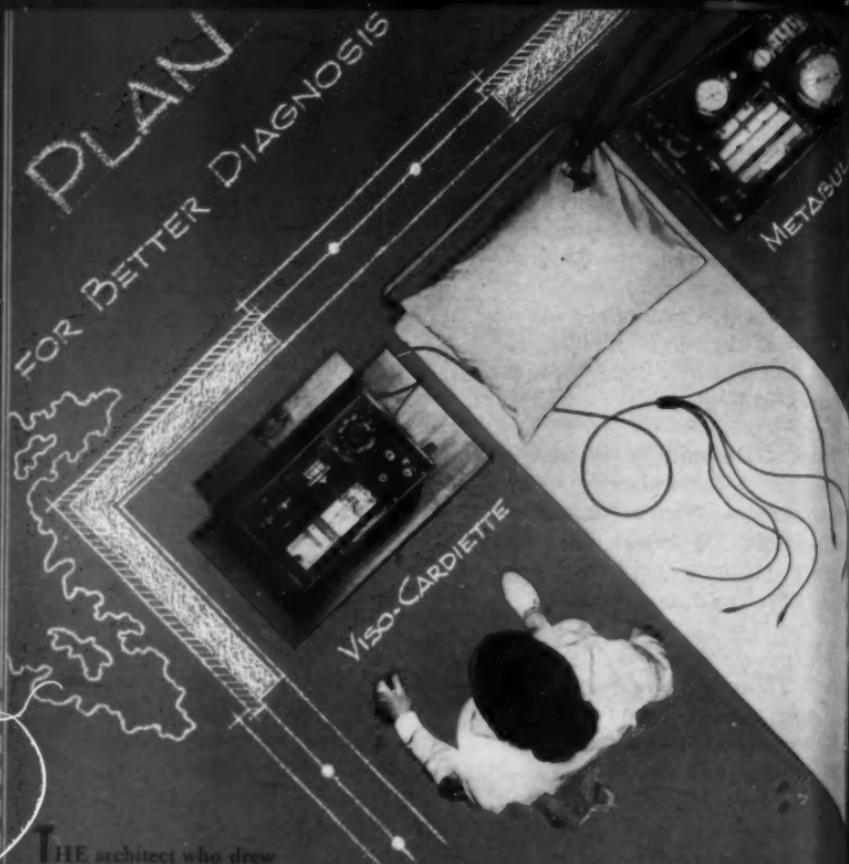
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That, of course, was left to your planning, and only you know enough of the "anatomy" of your practice to decide which furnishings and instruments are needed.

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had to do was mark an "X," how could you be sure he even knew how to write? Other states raised similar objections.

The Revolt Subsides

Since then, the National Board has done a good job of mending its fences. Four states—Nebraska, Kansas, South Carolina, and New Mexico—have already returned to the national fold. And there's some hope that others among the nine hold-outs will come back in. The Board has been working hard to regain their esteem. For instance:

1. It has decided that it will examine no more foreign doctors except when *asked* to do so by a state board. (Actually, it has never certified more than two or three dozen medical D.P.s a year.)

2. It has re-emphasized the fact that it has no intention of usurping states' rights and of setting up a Federal system. Says Dr. Robert A. Moore: "Clearly, the National Board is not a licensing agency, even if we wanted it to be—and we do *not*—because under our constitutional form of government the licensing of physicians is re-

served to the states. The National Board is not connected with any government, either federal or state . . ."

3. It has tried hard to explain its examination technique. "Many states," says a recent Board publication, as if breathing a sigh of relief, "look with favor upon the improvements in the validity and reliability of the National Board examinations. The . . . grades now have more accurate meaning."

Rx for Frustration

As matters stand today, the National Board offers an excellent long-range answer to the frustrations of the migration-minded doctor. It gives the states a better means of guaranteeing professional qualifications to the public than they now have. As far as it goes, it offers the diplomate freedom to practice where he pleases.

The trouble is that it doesn't go far enough. Indeed, the diplomate runs into some of the same restrictions that the non-diplomate does when he seeks a license through reciprocity. For though the Board man is accepted in forty-five of the fifty-four medical board juris-

THE LICENSURE MESS

dictions, he isn't always accepted wholeheartedly.

Hawaii, Illinois, Rhode Island, and Wyoming, for example, require supplementary oral examinations. And eight states refuse to accept the Part I examination in lieu of their own basic science requirement: Arizona, Colorado, Nebraska, New Mexico, Oregon, Rhode Island, South Dakota, and Washington.

Comb all the burrs out of these various dogs in the manger, and you find that only thirty-three state and territorial boards welcome National Board diplomates without further questions.

Turner's Key

One of the National Board's strong supporters is Dr. Edward L. Turner, secretary of the A.M.A. Council on Medical Education and Hospitals. He believes the Board "holds the key to the solution" of the licensure mess. And he emphasizes that examination and licensure are two different functions.

This distinction, other observers agree, is the clue to the ultimate answer: You can't take licensing away from the state boards, they say. *But*, they ask, why not make the National



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THE LICENSURE MESS

Board of Medical Examiners the voluntary, authorized examining agent for all state boards? If this were done, all license candidates would at least be assured of a fair and equal test.

Asked how he would feel about losing the examining function, one state board secretary has replied: "Our board doesn't feel that we have an empire to maintain."

Where to Put Pressure

He has pointed out, too, that if the testing process were left in the hands of the National Board, the local jurisdictions might pay more attention to functions they've been neglecting. They could encourage investigation of medical practice act violations. They could hear charges and discipline violators.

What the National Board can do best is the examining and the certifying, while the state board still does the licensing. The state board also keeps its investigatory and judiciary functions. And it collects its fees, as always.

Who is to campaign for all this? Logically, your state board men. If you put the finger on such doctors, you'll probably be putting it on the primary pressure point. END

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DOSAGE: One or 2 tablets as required.

Each Plimasin tablet contains 25 mg. Pyribenzamine® hydrochloride (tripelennamine hydrochloride CIBA) and 5.0 mg. Ritalin® (methyl-phenylacetate CIBA).

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Tips on Tax Deductions For Casualty Losses

By Joseph F. McElligott

If last year's storms hit you hard—or if you lost property in other ways—here's how you can cushion the blow at U.S. income-tax time

As a result of the recent rash of hurricanes and floods, an unprecedented number of taxpayers are expected to list casualty losses on their 1955 Federal income tax returns. Are you among them? If so, you may want to study the Treasury's detailed booklet of advice on claiming such losses.

The pamphlet ("How the Federal Income Tax Applies to Losses from Hurricanes, Floods, and Other Disasters") is hot off the press. You can get it free from your local Internal Revenue office. It covers most of the finer points.

Finer points notwithstanding, you can tell quite simply whether you're allowed to claim a casualty loss deduction. Just remember that *uninsured* losses resulting from any of nature's tantrums—including blizzards, droughts, and fires—are deductible. So are uncompensated losses resulting from such human

THE AUTHOR is a tax and medical management consultant in New York City.



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TAX DEDUCTIONS FOR CASUALTY LOSSES

vagaries as theft or automobile damage (provided, of course, there's no willful negligence involved).

Cross-Country Report

Reports from across the country indicate that medical men will be claiming such deductions for just about all allowable reasons. Some cases in point:

At least a dozen doctors in one small California city suffered more than \$5,000 worth of deductible damage to their homes and offices in last December's floods.

Among the hardest hit in this area was an ophthalmologist who, as the flood waters rose, managed to move his most expensive instruments from his office to his home. By doing so he held down his office losses to \$2,000 worth. But then seven feet of water poured into his home, ruining not only the instruments but a total of \$20,000 worth of property. The doctor and his family barely escaped ahead of the crest.

An ALR man in the same city had to chop his way through his own roof, from which he and his



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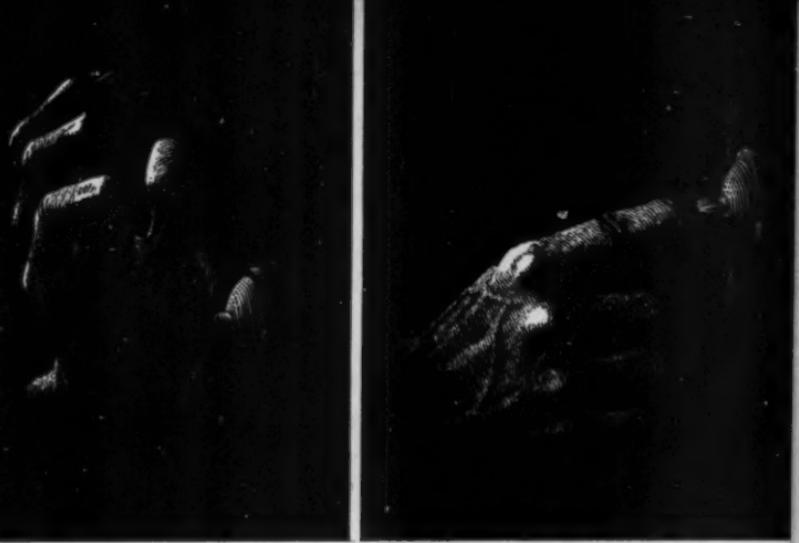
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The sustained effect of Acetycol is based on the relationship between aspirin and para-aminobenzoic acid. A relatively low dosage of aspirin produces high salicylate blood levels in the presence of PABA. The effectiveness of Acetycol in gout or cases of a gouty nature is due to the inclusion of salicylated colchicine.

Acetycol also contains three important vitamins, often lacking in older and rheumatic patients: ascorbic acid, to prevent degenerative changes in connective tissues; thiamine and niacin, for improved carbohydrate utilization and relief of joint pain and edema.

Usual dosage — 1 or 2 tablets three or four times a day.

Each Acetycol Tablet contains:

Aspirin	325.0 mg.
Para-aminobenzoic acid	162.0 mg.
Colchicine, salicylated	0.25 mg.
Ascorbic acid	20.0 mg.
Thiamine hydrochloride	5.0 mg.
Niacin	15.0 mg.

Supplied: Bottles of 100 and 500

Acetycol

TRADEMARK

to relieve rheumatic pain

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TAX DEDUCTIONS FOR CASUALTY LOSSES

family were evacuated by helicopter. If his insurance won't cover the damage, it's a legitimate tax deduction. Other deductible losses reported by doctors in the area ranged as high as \$25,000.

Less dramatic reports of deductible losses came from other areas. Here's a variety of examples:

One East Coast physician who visited his waterfront summer cottage last year, after Hurricane Hazel had subsided, found that the house had escaped with

only a few broken windowpanes. But a new boat dock built for the forty-foot cruiser he'd ordered was a total wreck. The dock wasn't insured. So its full cost (\$1,500) counts as a deductible casualty loss on his tax return.

In the Midwest, a medical secretary arrived at the office one morning to find the door jimmied open and the desk lock broken. The cash box, with \$125 in receipts, was missing. Her employer can deduct that amount as a casualty loss. [MORE▶]



"It seems there's a complication right about here."

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NEW ANTI-ANXIETY FACTOR

*with muscle-relaxing properties
relieves tension*

Usual dosage: 1 tablet, t.i.d.

Supplied: Tablets, 400 mg., bottles of 50

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the first basic amphetamine improvement in 10 years



Synatan

brand of L-damphetamine protocolloid complex, Iraian-Neister



just 1 dose a day

for smooth, sustained and
dependable d-amphetamine
therapy . . . release is
independent of any particular pH
of the gastrointestinal tract . . .

Synatan CAN BE EMPLOYED

WHENEVER THE SUSTAINED
CONTROLLED ACTION OF
DEXTRO-AMPHETAMINE IS DESIRED

as indicated in...

obesity . . . alcoholism
... menopausal
and premenstrual
depression . . .
neurasthenia . . .
post-partum depression
... general fatigue
... chronic nervous
exhaustion . . .
fatigue of secondary
anemia . . . geriatric
depression . . . drug
induced drowsiness

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advantages...

Gradual and uniform
release of amphetamine by
simple principles
of physical chemistry

Independent of any
particular pH of
the gastrointestinal tract

Independent of wax or
enteric coating of any kind
for smooth gradual
release of amphetamine

Minimal, if any, side effects

More dependable results

Economical

To serve your
patients today—

Call your pharma-
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tional product in-
formation you may
need to help you
prescribe Synatan.

Each Synatan tablet is
composed of a protocolloid
complex containing
tanphetamin (*dextro-*
amphetamine tannate) 17.5
mg., equivalent to 5.25 mg. of
d-amphetamine base.

One or two Synatan tablets
at 10 a.m. ordinarily will
produce all-day control
of your patient.

In bottles of 50 and 500

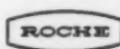
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GENTLE

is the word
for Noludar

Mild, yet positive in action, Noludar 'Roche' is especially suited for the tense patient who needs to relax and remain clear-headed—or for the insomniac who wants a refreshing night's sleep without hangover. Not a barbiturate, not habit-forming. Tablets, 50 and 200 mg; elixir, 50 mg per teasp.

Noludar® brand of methyprylon
(3,3-diethyl-5-methyl-
2,4-piperidinedione)



Original Research in
Medicine and Chemistry

TAX DEDUCTIONS FOR CASUALTY LOSSES

During 1955, one doctor's orchard was destroyed by a tornado; another doctor's swimming pool cracked in a sudden freeze-up; still another man's hunting cabin was set afire by lightning. They can deduct these losses to the extent that they weren't insured. And if you suffered any similar loss, your taxable income can be reduced accordingly.

Spreading Losses

What if the amount of your loss exceeds your income for the whole year? In such an event, you're permitted to spread the loss over an eight-year period—a tax break that can save you real money.

Furthermore, in such cases, the law lets you recover your money quickly by carrying the loss back as much as two years to offset income and get tax refunds. If that doesn't exhaust your loss deduction, you continue to apply the remainder against future income.

Separate Deductions

Although almost everything you own can be "deductibly lost" through casualties, be careful to deduct *separately* for business and personal assets on your tax forms.

Losses of personal assets (things not used in your practice) should be deducted on page 2 of Form 1040, under the

High Time

An old country doctor had just finished delivering a farm family's tenth baby in ten years. He was aware that the mother's health wasn't too good. As he sat sipping a cup of coffee in the kitchen, the father came up to him.

"You know, Doctor," he said, "we've had so many kids that we've plumb run out of names. I sure don't know what to call this 'un.'"

"If I were you," said the doctor thoughtfully, "I'd call it quits!"

—D. O. FLYNN

CASUALTY LOSSES

Selective cough control through...



Pfizer Laboratories, Brooklyn 6, N.Y.
Division, Chas. Pfizer & Co., Inc.

heading "Losses from fire, storm, or other casualty, or theft."

Losses of business assets should be deducted on Schedule C (line 15).

In case the damaged property was used for *both* personal and business purposes, a percentage of the deduction, according to use, can be entered in both places.

Question of Timing

As a rule, you must report a casualty deduction on your tax return for the year in which you suffered the loss. Thus, deductions for hurricane damage suffered last year must be taken on your return for 1955 (with the further possibility of spreading them as explained on the preceding page).

But in cases of theft or embezzlement, it's often impossible to determine the *exact* year in which the loss took place. So losses due to theft are deductible in the year of discovery.

Here are some other tips on casualty loss deductions:

¶ If the damage is extensive, it's a good idea to have an appraiser value the property. (The appraiser's fee is deductible as a cost of preparing your tax return.)

¶ Even if the loss is a small

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CASUALTY LOSSES

one, it's wise to keep some proof of the damage. A photograph will usually help.

¶ If you lost a family heirloom, you may deduct *only* its worth in cash—not its sentimental value to you.

¶ When claiming a loss from theft, you'll probably need proof that the article isn't merely lost. If possible, get statements from witnesses concerning physical evidence that the theft took place (a broken lock or window-pane, for instance). Police breaking-and-entering records may also help support your claim.

Supporting Statement

¶ Finally, I strongly advise attaching to your return a separate sheet of paper on which you give a detailed statement of how you arrived at the amount claimed as a deduction. Include the date of the casualty, a complete description of the property before and after, and the sources (appraisal figures or itemized repair bills) used to fix the amount of loss. I've known of cases where lack of such a detailed supporting statement has caused the return to be set aside for a complete field audit conducted by a revenue agent in the doctor's office.

END

...selective
inhibition of
the cough
reflex with

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BRAND OF CARBETAPENTANE CITRATE

non-narcotic, non-opiate, highly palatable antitussive agent

TOCLASE EXPECTORANT COMPOUND

Sugar-free, pleasant-tasting, cherry-flavored, amber-colored syrup.

Bottles of 1 pint.

TOCLASE SYRUP Pleasant-tasting, cherry-flavored, red-colored syrup.

Bottles of 1 pint.

TOCLASE TABLETS For convenience at work or recreation. 25 mg. tablets, bottles of 25.



Why Some Medical Groups Get Into Hot Water

By Hugh C. Sherwood

This preliminary report on the large-scale A.M.A. survey of clinic practice in the U.S. reveals several common sources of potential friction

A surprising number of doctors take the plunge into group practice after having given "too little thought and study" to their group's formation and future growth.

That's the tentative conclusion of a committee set up by the A.M.A. Council on Medical Service. The committee has visited forty-eight groups in every part of the country except the West Coast; it plans to visit hundreds more. Its ultimate aim: to help new groups avoid the early problems encountered by old ones.

The smallest of those medical groups already studied have three to six members; the largest, eighteen or more. But large or small, many of them have run into several common problems that proved difficult to solve.

1. *Choosing and keeping group members.* Of the forty groups that provided information on their formative years, nine said they'd had considerable trouble

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TRADEMARK
Ear Drops

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OTITIS MEDIA



Otamylon is a clear, odorless, sterile, viscous liquid containing Sulfamylon HCl and benzocaine in propylene glycol.

Otamylon is effective against all commonly encountered ear pathogens. Through its local analgesic and hygroscopic effect, Otamylon quickly soothes the irritated or inflamed surfaces and promotes prompt healing.

Manner of Use: After gently cleansing and drying the ear canal, Otamylon (2 or 3 drops or moistened wick) is applied three or four times daily.

Supplied: Bottles of 15 cc. with dropper.

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Winthrop

LABORATORIES NEW YORK 16, N.Y. - WINDSOR, ONT.

MEDICAL GROUPS IN HOT WATER

in "selecting physicians to form a well-rounded professional staff." Six others had suffered from conflicts among their doctors.

They Don't Get Along

What's worse, more than one-third of the smaller groups confessed that they've never developed a completely satisfied membership. And several larger groups reported that they still have "personality difficulties."

2. Choosing and working with group administrators. About half the groups surveyed said they first ran into trouble when they

tried to agree on who'd be responsible for the "ordinary conduct of business." Many of the organizations apparently resist the idea of hiring business managers. Or, if they do hire managers, they don't really give them a chance to make good.

Net result: Nearly half the groups admit they still have serious administrative difficulties.

Slicing the Melon

3. Distributing group profits. Fifteen groups mentioned division of income, along with poor administration, as the major

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clear awakening...

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AS A HYPNOTIC 0.5 GM. OR BEDTIME. AS A DORMEUSE SEDATIVE 0.25
GM. 1-4, OR 0.5 GM. DORMEDEC. SUPP. TABS (each) 0.25 GM.
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DYSPEPTIC DOT LIKES HER MENU HOT

Her meals have that lava flavor.
Hot, thick, and spicy.

But such volcanic doings may soon erupt into nutritional deficiency. That's when Dot will be asking for your advice. She'll need a sensible dietary along with effective multivitamin therapy. *Abbott*

GIVE HER A *Dayalet®* A DAY

10 important vitamins in
each tiny  tablet

Vitamin A.....	3 mg. (10,000 units)
Vitamin D.....	25 mcg. (1,000 units)
Thiamine Mononitrate.....	5 mg.
Riboflavin.....	5 mg.
Nicotinamide.....	25 mg.
Pyridoxine Hydrochloride.....	1.5 mg.
Vitamin B12.....	2 mcg.
Folic Acid.....	0.1 mg.
Pantothenic Acid.....	5 mg.
Ascorbic Acid.....	100 mg.

603180

MEDICAL GROUPS IN HOT WATER

problem of their early years. A number of the smaller clinics still consider this their biggest headache.

Just how do the groups divide their incomes? The survey so far reveals that most of them use one of the following well-known systems:

The Point System

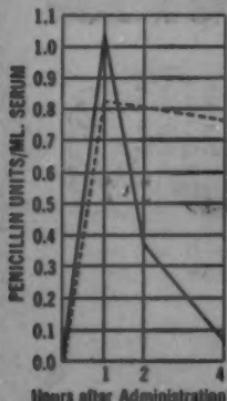
¶ Each medical procedure is allotted so many points. The individual doctor's income depends on his point score in relation to the total points earned by the group.

¶ Each doctor gets a percentage of the group income, as agreed upon in advance. The group members' percentage shares are not necessarily equal, however.

Works Well If . . .

¶ Each senior partner shares equally with his peers. This method "appears to work fairly well," says the committee, "if the senior partners . . . are of approximately the same age and capacities and lacking in personal jealousies." But it's less successful in large groups where

Now! Palatable Oral Suspension Gives Higher, Faster Blood Levels than Twice the Dose of Injected Procaine Penicillin



PEN-VEE • Suspension
300,000 units
— Procaine Penicillin G,
600,000 units (one injection)



This ready-mixed, stable, and pleasantly flavored suspension is supplied as follows: PEN-VEE Suspension, 300,000 units per 5-ounce spoonful, bottles of 2 fl. oz. Also available PEN-VEE Oral Tablets, 200,000 units, scored, bottles of 36; 500,000 units, scored, bottles of 12.

PEN-VEE^{*} Suspension
Benzathine Penicillin V Oral Suspension
ORAL PENICILLIN
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How to win friends ...

The Best Tasting Aspirin you can prescribe.

The Flavor Remains Stable down to the last tablet.

15¢ Bottle of 24 tablets (2½ grs. each).



We will be pleased to send samples on request.

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of Sterling Drug Inc.

1450 Broadway, New York 18, N.Y.

MEDICAL GROUPS IN HOT WATER

"there is considerable variation in earning power."

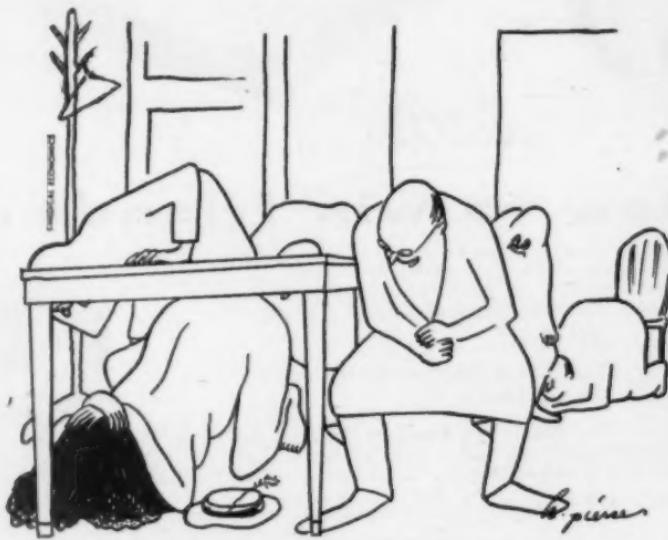
¶ Each doctor gets a specified salary. The amount is decided upon from year to year. It varies according to his work, his training, and the length of time he's been with the group.

No Best Way

None of the income-division systems has "yet emerged as being outstandingly successful," the A.M.A. committee observes. And one facet of the problem

particularly bothers some of the surveyed groups: How to provide for an orderly progression from junior to senior partnership? Because of a common failure to find a satisfactory answer to this problem, some unhappy junior partners never *do* reach senior status. As a result, some of them return to solo practice.

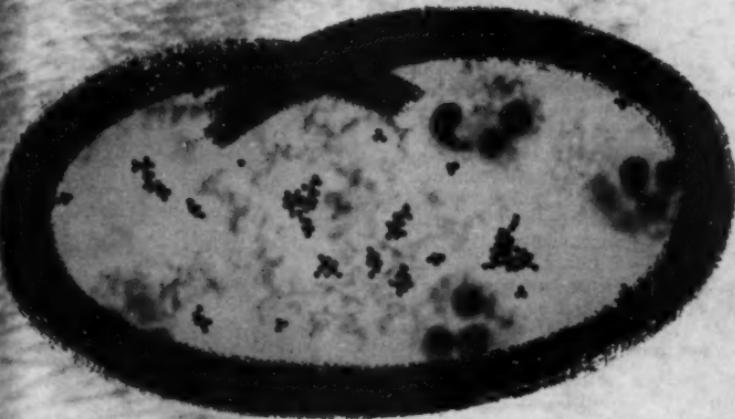
Concludes the committee: "It [is] in the best interest of both parties that a junior partner progress to full partnership with a fair degree of rapidity." END



"If you please, Miss Goldamer, the Board would like to take another little look-see."



high antibacterial and antifungal potency



STEROSAN®

CREAM AND OINTMENT

(brand of chlorquinadol)

in skin infections due to fungi and gram-positive organisms

A new iodine-free oxyquinoline derivative, STEROSAN has shown favorable results in controlled comparison with other recognized anti-infective medications.*

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*Dermatophytosis Folliculitis Furunculosis Impetigo contagiosa
Impetiginised eczema Infected dermatides Infected seborrhea Pyoderma Sycosis*
The bacteriostatic and fungistatic action of STEROSAN is not hampered by heavy bacterial concentration, pus or organic debris. Sensitization to STEROSAN has not been observed, and primary irritation has been seen only in rare instances.

STEROSAN® (brand of chlorquinadol) Cream and Ointment, tubes of 30 Gm.

*Tronstein, A. In: J. Invest. Dermat. 13:119, 1949.



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Enriched Bread...

in the Ideal Reducing Diet

High in palatability and high in many nutrients, enriched bread shares notably in helping make the reducing regimen appealing and adequate nutritionally. In so doing it helps "to assure weight reduction without irritability and personality change" as well as "to avoid self defeat due to physical weakness and consequent inactivity."* Furthermore, the "ideal reducing diet" makes for increased likelihood of a permanent change from excessive eating to normal food habits "tuned to self control rather than outright abnegation."

Providing generous amounts of protein, B vitamins, and minerals, enriched bread goes far toward making the low caloric regimen adequate in these nutrients. Its protein, containing an average of 10.5 per cent of milk protein, functions for growth and repair of tissues as well as for maintenance. Fresh or toasted, or as tasty sandwiches, enriched bread provides eating satisfaction, an essential for making the reducing regimen tolerable.



The nutritional statements made in this advertisement have been reviewed by the Council on Foods and Nutrition of the American Medical Association and found consistent with current authoritative medical opinion.

Contribution of 6 Slices of Enriched Bread

	Nutrients and Calories	Percentages of Allowances**
Protein	11.7 Gm.	18%
Thiamine	0.33 mg.	22
Niacin	3.0 mg.	20
Riboflavin	0.21 mg.	13
Iron	3.3 mg.	28
Calcium (average)	122 mg.	15
Calories	379	13

*Berryman, G. H.: Obesity—A Brief Review of the Problem, *Metabolism* 3:544 (Nov.) 1954.

**Percentages of daily allowances for fairly active man 45 years of age, 67 inches in height, and weighing 143 pounds: Recommended Dietary Allowances, Washington, D.C., National Academy of Sciences—National Research Council Publication 302, 1953.

AMERICAN BAKERS ASSOCIATION 20 North Wacker Drive • Chicago 6, Illinois

Commitment Papers: Don't Let Them Trip You

By Henry A. Davidson, M.D.

They don't cause trouble very often—but when they do, they expose you to personal liability. The best safeguards in commitment cases are these

Every year, some 400,000 signatures of doctors appear on commitment papers. Rather rarely does any such signature backfire. In the few cases where it does, the unwary physician has probably erred in one of the following ways:

1. He has tried to short-cut the procedure by using a prescription blank or informal memorandum instead of the regular commitment paper.
2. Or he has signed a paper in a case in which he's personally involved.
3. Or he has taken somebody else's word for the patient's actions.

Here's a recent example of the first of those booby traps: An Eastern physician realized that one of his patients had to be committed. But he didn't want to get "involved in red tape." So, instead of filling out a commitment paper, he wrote on an Rx blank:

DR. DAVIDSON is the author of "Forensic Psychiatry" (The Ronald Press, New York, 1952), a standard textbook on the subject.

introducing

a new substance

flexin*

the first orally effective lissive[†]

dosage: Adults—1 to 2 tablets with food or immediately after meals. Children—1 tablet two to four times a day.

supplied: Yellow, soluble tablets of 50.

lissive: Spasmolytic, relaxant, with normal function.

*T.M.

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**true spasmolysis
of skeletal muscle
in musculoskeletal and
neurological disorders
effective up to 6 hours**

Synthesized and characterized by McNeil Laboratories, FLEXIN is the first skeletal muscle relaxant truly effective by mouth. Its lissive action relieves the disability and pain of skeletal muscle spasm—common denominator of many musculoskeletal and neurological disorders.

not a mephenesin derivative

FLEXIN provides superior and long lasting—up to 6 hours—spasmolysis of voluntary muscle in low back syndromes, fibrositis, strains, sprains, and in noninflammatory rheumatic and arthritic disorders.

Striking results are reported in cerebral palsy. Over 65 per cent of spastics obtained definite reduction of excessive muscle tone. In addition, a highly significant number of patients with multiple sclerosis, spinal spasticity and Parkinsonism were benefited.

McNeil Laboratories, Inc., Philadelphia 32, Pa.

McNEIL

COMMITMENT PAPERS CAN TRIP YOU

"Mrs. A is in need of treatment but, because of mental confusion, does not realize it."

With this as a ticket, Mrs. A's husband tried to get her placed in a city hospital's psychopathic ward. The hospital refused. The woman soon recovered from her confusional state and, on the basis of the prescription blank, sued the doctor for libel.

Defense Isn't Cheap

The case never reached court. But the doctor had some embarrassing moments and some far-from-trifling legal costs.

Or take the Midwestern M.D. who scrawled on a memo pad: "In my opinion, Henry White should be hospitalized for mental observation."

Sounds innocent, doesn't it? There was nothing in it about insanity, confusion, or psychosis.

Enter the Sheriff

But the patient's brother took the note to the sheriff. Since the nearest state hospital was seventy-five miles away, the sheriff did what he thought he had to do: He locked Henry White in the local cooler until regular commitment papers could be

processed. As the sheriff saw it, "observation" means "insanity," and "insanity" means "violence."

The patient got his observation, all right. It showed some paranoid ideas but no psychosis. Result: The doctor was sued for effecting the jailing of an innocent man.

In both the above cases, the doctor erred by using an informal substitute for what has to be a formal procedure. In a democracy, no one may lightly take away a person's liberty. This can be done *only* through due process.

Your Own Relatives

Take a second trap now: signing a paper in a case where the doctor is personally involved. What would you do in the following situation?

Suppose it just happens that your brother is married to a beautiful lush. She's always drunk, often destructive. After trying everything else, he asks you to commit her to a state hospital.

You reason that this is a good idea. Your brother can't afford a \$20-a-day private "sanitarium." And certainly no woman in her right mind would keep

COMMITMENT PAPERS CAN TRIP YOU

getting drunk day after day. But you naturally want to keep the matter as quiet as possible. So you and your classmate who practices ten miles away make out the commitment papers.

Maybe that'll save your brother from being gossiped about. But it may also get *you* in trouble. The law says that a doctor may not certify the commitment of a relative.

Is your sister-in-law a rela-

tive? I don't know. But I *do* know that it's bad taste to commit her. At the very least, it can cause raised eyebrows in some very important circles.

The Third Trap

Now let's consider the third possible mistake: taking someone else's word for the patient's actions. Suppose, for instance, your good friend, Dr. P., calls you at 11 P.M. to tell you that he



"Just thought I'd drop in to see if you still want that second opinion, Mrs. Clark."

COMMITMENT PAPERS CAN TRIP YOU

has spent the last hour at the home of a patient. The patient's father, a senile gentleman, has become disturbed, is screaming, tearing off his clothes, and so on.

Says Dr. P: "I've given a sedative and signed a commitment paper. Will you come over and sign the other half?"

All you see when you get there is an old man snoring away in a sedative-blanketed sleep. Obviously you can't, of your own knowledge, say that the patient is disturbed, delusional, disoriented—or anything except asleep.

If you're smart, you'll wait un-

til the effect of the drug has worn off. This is awkward and time-consuming. But if you fill out a paper now, you've got to put down that, *in your presence*, the patient said or did queer things. Rather than sign such a document, you'd better hang around a while.

Here's a similar problem: You find a patient who's badly confused. He doesn't know or seem to care what day it is. But you know he was given some medication a few hours ago, and so his confusion *could* be due to its toxic effects. Remember that

protects your pregnant patients

one tablet t.i.d.

**DECHOLIN.
with Belladonna**

(decholin, belladonna, and belladonna alkaloids)

promotes bile flow — combats bile stasis

helps prevent gastrointestinal distress

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**Ulcer protection
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lasts all night:**

Pamine*

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Tablets

Each tablet contains:
Methscopolamine bromide 2.5 mg.

Average dosage (ulcer):
One tablet one-half hour before meals, and 1
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Supplied: Bottles of 100 and 500 tablets

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Each 5 cc. (approx. 1 tsp.) contains:
Methscopolamine bromide 1.25 mg.

Dosage:
1 to 2 teaspoonfuls three or four times daily.

Supplied: Bottles of 4 fluidounces

**Sterile
Solution**

Each cc. contains:
Methscopolamine bromide 1 mg.

Dosage:
0.25 to 1.0 mg. ($\frac{1}{4}$ to 1 cc.), at intervals of 6 to 8
hours, subcutaneously or intramuscularly.

Supplied: Vials of 1 cc.

*TRADEMARK, REG. U. S. PAT. OFF.—THE UPJOHN BRAND OF METHSCOPOLAMINE

The Upjohn Company, Kalamazoo, Michigan

COMMITMENT PAPERS CAN TRIP YOU

even you (or even I) could be made to look psychotic by loading up with toxic drugs.

Technically, you're in the clear here, if you faithfully write down what the patient says and does, and if you indicate that this may be the effect of the medication. But don't let yourself be quoted as having stated categorically that this patient has a chronic psychosis.

Other Safety Steps

In addition to the three major precautions, there are other legal safeguards you can take. Among them:

Spend a reasonable amount of time with the patient. You need

it in order to get the picture in full perspective. Maybe it's possible to take a quick look at a taciturn individual huddled in a corner and then write down that he's depressed, inaccessible, gloomy, melancholy, delusional, and mute. But that's a lot of adjectives for a one-minute glance.

Give the patient a chance to tell his story to you alone. If interested relatives remain in the room during every moment of your visit, the patient may claim that they exerted undue influence. And you may be asked some embarrassing questions later on.

Don't fail to do a thorough physical examination. There's a

False Perspective

As a third-year medical student in the ENT clinic, I was given a new patient to examine: a middle-aged woman with glasses and a pointed nose. When I set about examining her nostrils, I couldn't seem to see much. Feeling that her glasses were perhaps obscuring the picture, I said: "Would you please take them off?"

To my dismay, the woman calmly reached up and removed her nose. It seems she wore a particularly lifelike nasal prosthesis—and that's what I had been trying to examine.

—MAX S. SMALL, M.D.

in patients with colds...sinusitis...rhinitis



unplug that stuffed-up nose

orally with

Novahistine®

The marked synergistic action of a vasoconstrictor with an antihistaminic drug provides marked nasal decongestion and promotes normal sinus drainage. Oral dosage avoids harmful misuse of topical agents...eliminates nose drop rebound. Novahistine causes no jitters or cerebral stimulation.

3 dosage forms
elixir
tablets
fortis capsules

Each Novahistine Tablet or teaspoonful of Elixir, provides 5.0 mg. of phenylephrine HCl and 12.5 mg. prophenpyridamine maleate. Novahistine *Fortis* Capsules contain twice the amount of phenylephrine for those who need greater vasoconstriction.

PITMAN-MOORE COMPANY Division of Allied Laboratories, Inc., Indianapolis 6, Indiana

MEDICAL ECONOMICS · MARCH 1956 261

COMMITMENT PAPERS CAN TRIP YOU

temptation, if the patient is obviously psychotic, to make the physical examination a sort of once-over-lightly. But when the patient gets to the hospital, he'll have a thorough going-over. If it then appears that you hadn't discovered his hypertension, goiter, heart murmurs, hernias, or active pulmonary tuberculosis, the staff will start wondering. Nobody will sue you; but it seems an unnecessary way to invite trouble.

Slip of the Pen

Be especially careful in writing dates. A commitment paper that isn't used becomes invalid after a certain number of days (ten in most places). Suppose, by slip of the pen, you write "March 1" instead of "March 11." The family delivers the patient on March 14, but the hospital refuses him because the examination was made—apparently—thirteen days earlier. You get a frantic phone call and you authorize a relative to make the correction on the paper.

That's bad! It's tampering with an official document. Even though it's a nuisance, better have the paper returned to you, so you can make the correction

yourself and initial the change.

Don't do anything that gives rumor-mongers a chance to say you have a personal interest in the commitment. Don't, for example, drive the patient to the hospital yourself. That's sometimes illegal and always in poor taste. Similarly, be wary of committing patients to a hospital with which you're associated.

And now, finally, a few tips for the younger doctor who may be something of a novice in this field:

Find out what's the minimum period of practice required in your state before you may certify commitment. Also, if you're a new practitioner locally, find out whether internship, residency, military service, and practice in another state count toward that minimum time period.

Are You Qualified?

Suppose, for instance, the law reads that a committing doctor must have been "in practice for at least five years." You've had a year of internship, three years of residency, two years in the Army, and four years in the state—totaling ten years of practice. Does this meet the legal re-

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*Belladenal®
Space'tabs**

*Antispasmodic-
Sedative*

*Economical,
Convenient
Dosage*

1 tab. q. 12 hrs.

Belladefine 0.25 mg.
(Levocet莨菪碱
of Belladonna)

Phenobarbital 50.00 mg.



Sandoz
PHARMACEUTICALS
HANOVER, N. J.

COMMITMENT PAPERS CAN TRIP YOU

quirement? Or do the words "in practice" mean private practice in the state? You'll need to know.

Be sure to read every word of what you're signing. On its face, the commitment paper may require a statement that the patient has to be confined "in his own interest," or "for his own safety," or "for the protection of others." You'd look foolish certifying as "dangerous to others" a

quietly deteriorating senile dement, lying in bed with a broken arm in a cast and a broken leg in an extension. Such a person might need "treatment in a mental hospital"; and if that's how the commitment paper reads, all right. But if he has to be homicidal to be committed, you can't honestly certify that he's a commitment case.

Make and keep a copy of the



"In nontechnical language, Mr. Gramley, you're a no-good bum!"

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COMMITMENT PAPERS CAN TRIP YOU

commitment paper. In most states, it's hard to make a carbon copy, because the papers are bound in booklets. But you don't want to swear to something—as you must on a commitment paper—unless you have a record of exactly what statements you're swearing to.

Legal Precaution

There's only one completely satisfactory way of dealing with possible future litigation: Make out two copies of the commitment. Keep the unsigned one in your own file.

What should you charge for signing a commitment paper? A recent study by an American Psychiatric Association committee showed that fees range from \$5 to \$50, with the average \$20 or \$25.

If you're a general practitioner, you should probably charge whatever you normally get for the same amount of time.

Some doctors charge more, on the theory that special responsibility inheres in commitment. But if your good faith is ever questioned, an unusually high fee looks unusually bad. END

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How Your Aide Can Keep Better Records

By Frances L. Marold

These pointers on systematising case-history routines and keeping track of house calls are based on experiences of the writer's clients

The files of professional management consultants bulge with illustrations of faulty record-keeping in doctors' offices. In my experience, though, such kinks can be ironed out easily if you show your secretary how to get to work on them.

The following suggestions may assist you in doing the job:

1. *Your aide needs a system that will help her keep case histories up-to-date and accessible.*

You need such a system, too. Here's an incident that made one medical man fully aware of the importance of this:

When he started to write a prescription, the patient said: "Don't give me that stuff you prescribed last spring. I quit taking it after a couple of days. It made me feel worse instead of better." [MORE►

THE AUTHOR is associated with Professional Management of Waterloo, Iowa. This is the third of several articles by her on the doctor-aide relationship.



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YOUR AIDE CAN KEEP BETTER RECORDS

The doctor stared blankly at the case-history card. He couldn't recall what "that stuff" was. And the card showed no entry for the patient's spring visit except the date.

"I don't seem to have a record of what I gave you," the doctor confessed. "Perhaps you'd better phone me the number of the prescription when you get home. We'll find out from the druggist what it was, and then I can prescribe something else."

But the patient had thrown the bottle away. All he could give the physician was the name of his drugstore.

The doctor's aide was then given the job of jollying the pharmacist into thumbing through prescriptions filled soon after the date of the patient's spring visit. She found out what medi-

cine to avoid. But the process took over three hours.

Now the doctor has a different record system. He had always insisted on writing the histories himself; but he had often been too busy to do a thorough job. And, as far as he was concerned, the aide could do nothing about them but file them away. Today, though, he proudly calls her his "watchdog."

Every day, she checks the history cards before returning them to the files. And if she feels that any of them haven't been fully updated, she puts the incomplete cards back on the doctor's desk. Thus, while the last visit is still fresh in his mind, he can fill in the missing data.

Dr. F is another man who's generally too busy for long sessions of history-writing. But case

No Stuffing?

A young newlywed called to complain that she'd had amenorrhea for three months. She also casually mentioned some breast changes and mild morning nausea.

"Doctor," she asked seriously, "do you think it might be because I ate too much turkey for Christmas?"

—WALTER S. FELDMAN, M.D.

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YOUR AIDE CAN KEEP BETTER RECORDS

histories are particularly important for him. The reason: As a junior partner, he makes all house calls, while the semi-retired senior practices in the office only. So Dr. F feels that the success of their joint practice depends on the reliability of its records.

The duty of keeping them in apple-pie order devolves on Miss Q, his aide. Here's their system:

When Miss Q takes a patient into the doctor's office, she brings along the case-history card. On it she has already recorded the date and the patient's weight. And she has attached any lab reports or X-rays.

Dr. F makes a sphygmomanometer reading and jots it down

before putting the instrument away. If he takes the temperature, he records that, too. But he avoids note-taking while discussing symptoms.

As soon as the patient leaves, the doctor makes a brief notation of symptoms, diagnosis, and treatment. If more than a few words are needed, he dictates them into a machine. This rarely takes more than a minute. Then he's ready for his next patient.

Miss Q tries to get all dictated remarks typed on the case histories before going home at night. And she files them, too. That way, the records are always in good shape. If a yesterday's patient phones the next morning, while Dr. F is out mak-



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BETTER RECORDS

ing house calls, the senior partner has all data at his finger tips.

2. *Your aide needs an effective method of keeping track of your house and hospital calls.*

Miss J told of a phone call from a patient who announced she was coming by for "some more of that medicine the doctor gave me last week." But Miss J hadn't even heard of the night call to the patient's home, much less of the medicine prescribed.

The doctor was at the hospital at the moment. So she had to have him paged there. "Isn't there some sure-fire way for me to get reports of house calls?" she asked our consultant later.

His answer: "Of course there is. Many doctors use house-call slips, as an aid to themselves as well as their secretaries."

Now the doctor keeps a pad of such slips always in his pocket. He records names and addresses on them. And each slip also has spaces for his notation of diagnosis, treatment, fee, and amount paid.

It becomes a matter of routine, then, for him to hand any filled-out slips to the girl whenever he enters his office. Thus she has all the information she needs to bring her records up-to-date.

END

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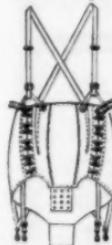
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Can Blue Shield Meet the Competition?

By Morris Crothers, M.D.

The plans can compete, says this doctor, only if they coordinate better, if they cope realistically with rising costs, and if you support them

Physicians have pioneered the development of health insurance. For the most part, the plans we sponsor still offer the best value to the buying public. Yet we seem to be losing the initiative to the commercial insurance companies.

Why? There are several reasons:

In the first place, Blue Shield has never had any real help from the medical profession on a national scale. The A.M.A. has generally shown little interest in it.

It's true that in recent years the Association has urged the growth of voluntary plans. But this delayed approval of an *existing* movement is very different from the exercise of initiative in *developing* a practical program.

If you consider the make-up of the A.M.A.'s governing bodies, you'll realize that a resistance to new

THE AUTHOR, a general practitioner in Salem, Ore., is president of his state's Blue Shield plan, Oregon Physicians' Service.

CAN BLUE SHIELD COMPETE?

ideas has been virtually inevitable. The House of Delegates, the Board of Trustees, and the Councils are made up of doctors who are sufficiently well established and prosperous to be able to give time to organizational work. They have a natural conservative bias. They have a natural distrust of social pioneering—even though as individuals they may be the most warm-hearted and generous of men.

Thus, the A.M.A. has made little distinction between Blue Shield and the commercial insurance companies. It seems to

have felt that the responsibility for developing health insurance programs belongs to insurance company officials rather than to organized medicine.

The flaw in such reasoning is that "health insurance" isn't really health insurance any more; it's a form of contract practice. This has raised ethical and economic problems that can be solved *only* by doctors.

Some of these problems are pressing heavily on us. They require the attention of the entire profession—both collectively and individually.

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CAN BLUE SHIELD COMPETE?

Individual doctors are still somewhat reluctant to approve their own plans. They're particularly so when it's a question of service, rather than indemnity coverage.

Right to Charge Extra

Most physicians naturally prefer the indemnity approach. It's the best way, they feel, of preserving the traditional doctor-patient relationship—including the right to charge "the usual private fee." And certainly an

indemnity plan does permit more flexibility in setting a fee commensurate with the specific service rendered.

But "the usual private fee" phrase is sometimes just a euphemism for charging the insured patient a *higher* fee. For example, although few Oregon doctors will admit it publicly, many of them have *usual* private fees that correspond exactly to the fee schedules of Oregon Physicians' Service.

In fact, the sliding scale is al-



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CAN BLUE SHIELD COMPETE?

most a thing of the past in our state. Though our plan has a family income ceiling of \$6,000 for service benefits, it's rarely invoked. Most of our doctors never even inquire what the patient's income is. They don't need to.

Oregon Physicians' Service provides them with an acceptable fee. Compared with other areas, there's little call for charity work here. (Indigents' bills are paid by the state welfare commission at 50 per cent of the regular schedule.) And beyond any doubt, the patients prefer a fixed fee scale.

As the concept of the average fee for a given service becomes more firmly established, I believe that the individual physician's opposition to the service benefit principle of our Blue Shield plans will lessen.

'Almost Fatal Weakness'

Probably the most serious problem for Blue Shield is its geographic set-up. Like the medical profession that founded it, it's organized in small geographic units—many of them covering less than a single state.

In times past there were defi-

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nite benefits to such local autonomy. But it has now become an almost fatal weakness.

The nation's great unions and industries aren't organized on a local basis. Their workers want industry-wide health plans, *and they're going to get them*. If Blue Shield won't cooperate, the commercial companies will. Or else big business and the big unions will set up more and more closed-panel plans like Kaiser-Permanente.

Blue Shield has tried to meet this challenge through a system of interplan agreements. But at

best these are a hodgepodge arrangement. We're still at a serious competitive disadvantage. After all, the commercial companies do have uniform programs that can be set to work in any part of the country. We don't.

Well then, you may ask, why don't we simply abandon the health insurance field? Why keep up the struggle?

The best answer to that question: It would be against the public interest for doctors to give up. Competition is the life-blood of this country, in medi-

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CAN BLUE SHIELD COMPETE?

cine as in industry. The public would suffer if health insurance were left entirely to the commercial companies and the closed-panel plans.

Controlled Fees

And medicine would suffer, too. If the commercial companies became dominant, certain unpleasant things would probably happen. Just to mention one of them: The insurance company would set the fee and would make sure that the subscriber went to doctors of its selection. It could hardly be otherwise.

But if we don't abandon our plans—and I feel sure we won't—how can we strengthen them? Three things that need doing come to mind:

1. *We need a nation-wide system of Blue Shield plans*, able to write uniform benefits across the country. I think the problem of how to achieve such a system can be solved only by organized medicine, working through the A.M.A.

You're a Salesman

2. *We must make every doctor a salesman for his physician-sponsored plan.* Here's a huge

potential sales force, unmatched by that of any commercial company. And if the doctors really believe they're being treated fairly by their own plan, they will sell it.

3. *We must keep down Blue Shield's costs.* I mean medical, surgical, and hospital costs. Deductible and co-insurance features in every patient's contract would help—but not enough. Some additional way must be found.

Stop the Spiral!

We in Oregon think we can suggest that way. Let me tell you about our experience:

When health insurance operates on a service or full-paid basis, there's an immediate danger of spiraling costs. For the physician is impelled by both his professional pride and his own economic interests to do the most thorough job he can in treating his patients. He finds medical authority for almost limitless tests: annual gastrointestinal series, semi-annual sigmoidoscopic examinations, quarterly chest X-rays, etc.

The result: ever-rising premiums, to cover the expense of such services.

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The problem is to find a new limiting factor on costs. And we believe we've found one in Oregon. For the last three years, Oregon Physicians' Service has been making an intensive study of average case costs. We now have a record for almost every participating doctor in the state, and we can tell at a glance the *average* costs he runs up in treating a case.

We also have averages for the whole state, broken down by specialty and region. For example:

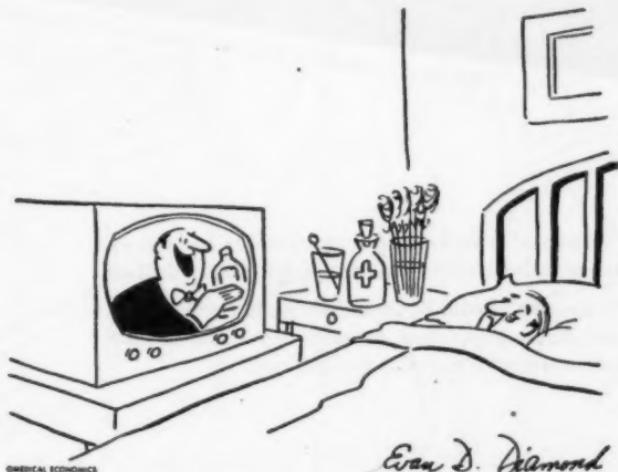
The average case cost index for Oregon is about \$47. (That's

what it costs for the average doctor to handle one case.) But for G.P.s alone, the cost is \$35; for clinic groups, \$45; for internists with a referred practice, \$50; for neurosurgeons, \$110; etc.

The Case of Dr. Y

Such figures give us a useful yardstick. For instance, we can examine the individual cost index for Dr. Y, a urologic surgeon:

Last year the average bill to O.P.S. for Dr. Y's cases was \$96, while the average bill for all urologists' cases was \$100. So



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Schultz et al.: Quart. J. Stud. on Alcohol 16:245 (June) 1955.

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CAN BLUE SHIELD COMPETE?

Dr. Y probably isn't running up costs unduly.

On the other hand, Dr. Z, a general practitioner, had an average case cost of \$130, compared with \$35 for all G.P.s. Dr. Z's expenses seem grossly out of line.

So what do we do about it? Well, we ask Dr. Z either to refund most of his excess costs to the plan, or to drop out as a participating physician.

Some men in this situation do

resign. But we've found that a good many others prefer to make refunds. We've already recovered as much as \$1,000 in several cases, and in one instance \$7,000.

As a result, the Oregon physicians who participate in O.P.S.—and about 90 per cent of them do—can generally be counted on to keep their expenses within bounds. Thus can Blue Shield satisfy the public without pricing itself out of the market. END



When to Call In A Collection Agency

By Arthur Owens

Want to save money and trouble? Don't consider turning over those past-due bills until you've made this sixfold test of their 'ripeness'

You've made sporadic efforts to collect a bill—and failed. You're considering turning the account over to a collection agency. That's when you smack up against the critical question of *timing*:

If you call in the collection agency too soon, you risk antagonizing the merely dilatory patient. But if you wait too long, the bill becomes more difficult—and more expensive—to collect.*

At what point, then, *should* you consider passing such bills on for collection?

Many physicians wait a year or more after treatment. But experienced collectors believe that, in most cases, six months is enough.

For one thing, they point out, the doctor usually exhausts his own collection resources within that time. For another, the fees of most collection agencies are higher after the sixth month. (An agency

*The National Association of Medical-Dental Bureaus estimates that you can collect only 43 per cent of your year-old accounts, only 23 per cent of those that are two years old.

WHEN TO CALL IN A COLLECTOR

that charges \$25 to collect a five-month-old bill of \$100 will often increase its fee to \$33.33 a month later.)

Is It Ripe?

Actually, though, the age of a debt is only one criterion for judging the best time to give it to a collection bureau. When there's been no action on a delinquent account for several months, think about turning it over to an agency *only* if it's ripe for such action.

How do you decide whether it's ripe to go to an agency? By

considering whether or not you've taken the following preliminary steps:

1. You've sent the bill to the person who's responsible for paying it. Suppose, for example, your patient is the minor child of divorced parents; and suppose your aide has been dunning the wrong parent. Such mistakes can—and often do—occur.

Take the advice of collection specialists: Make certain that your secretary records the name and address of the person responsible for the bill for each

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the
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patient...*

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...a mild cortical stimulant which gently lifts the patient out of fatigue and depression without swings of reaction caused by most stimulants. Ritalin counteracts the oversedation of barbiturates, chlorpromazine, rauwolfa, antihistamines...yet has no appreciable effect on blood pressure, pulse rate or appetite.

Supplied: Tablets,
5 mg. (yellow), 10 mg.
(blue) and 20 mg.
(peach-colored).

Dosage: 5 to 20 mg. b.i.d. or t.i.d., adjusted to the individual.

RITALIN®
hydrochloride (methylphenidate hydrochloride) (CIBA)



C I B A
SUMMIT, N.J.

WHEN TO CALL IN A COLLECTOR

new patient. And if there's any doubt about the legal debtor for an unpaid account, check on it before giving up your own efforts to collect.

Does He Understand?

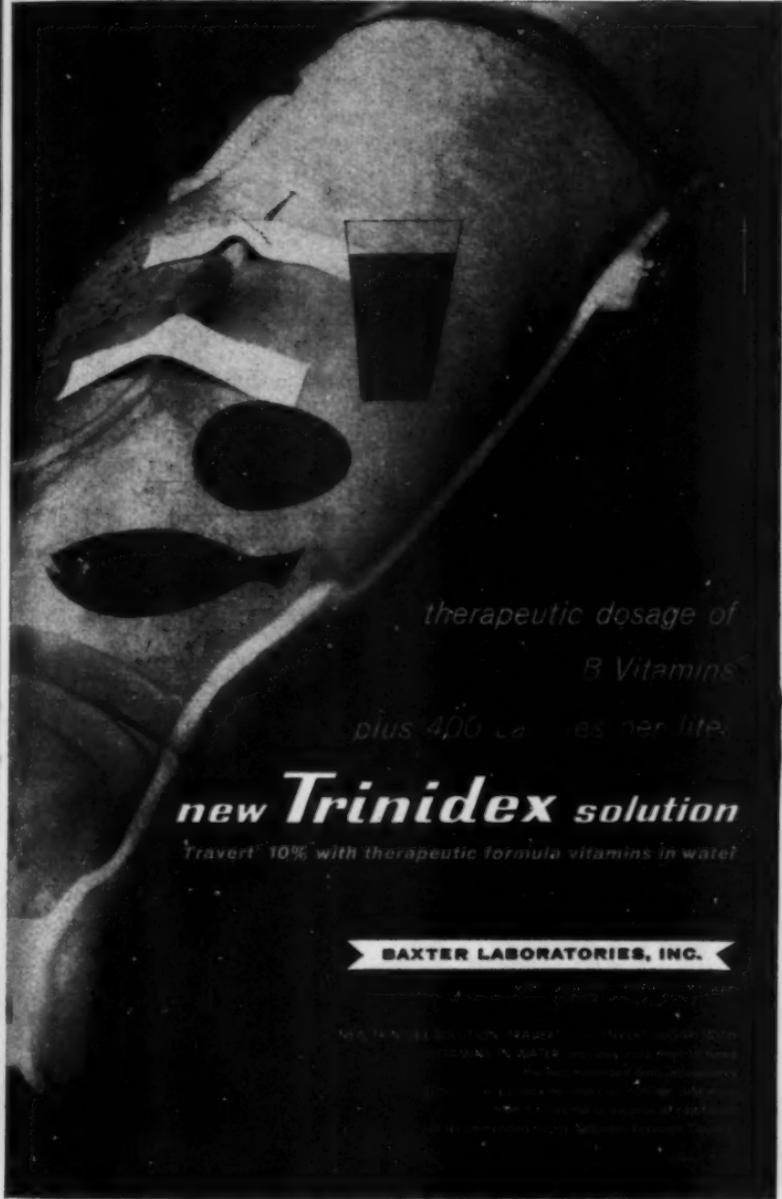
2. *You've seen to it that the patient understands all charges.* If he doesn't, he may be withholding payment simply because he thinks them excessive. This can easily happen if you make extra charges (e.g., for X-rays,

pathology, or consultation) without itemizing them. To avoid misunderstandings, it's obviously wise to get the patient's consent *in advance* for such special procedures as they become necessary.

3. *You've investigated the debtor's ability to pay.* Doctors with the best collection records establish such ability at the time of treatment. In cases of *temporary* inability to pay (because of unemployment, for example),



"Like yours on the rocks?"



therapeutic dosage of

B Vitamins

plus 400 cal. es per liter.

*new **Trinidex** solution*

Travert® 10% with therapeutic formula vitamins in water

► BAXTER LABORATORIES, INC. ◀

NON-IRRITATING SOLUTION. TRAVERT® 10% IN WATER. 1000 ml. BOTTLES
CONTAINING 10% TRAVERT® IN WATER. (Solutions containing 10% Travert®
and 10% Trinidex® in water are also available.)

DISTRIBUTED AND AVAILABLE ONLY IN THE 37 STATES EAST OF THE ROCKIES (except in the city of El Paso, Texas) THROUGH
AMERICAN HOSPITAL SUPPLY CORPORATION
SCIENTIFIC PRODUCTS DIVISION • GENERAL OFFICES • EVANSTON, ILLINOIS

the key to

higher analgesic potency

In a clinical evaluation of S.K.F.'s relatively new, non-narcotic analgesic—"Daprisal"—it was found that "mood elevation obviously was the key to the heightened analgesic potency of the preparation."

It was reported that three points were "particularly clear: (1) the analgesic efficacy of the preparation was at least equal—if not superior—to that of aspirin-phenacetin-caffeine-codeine; (2) side effects—when they did occur—were mild; (3) a definite sense of well-being was observed in the majority of patients treated."

Hanes, C.B.: *Am. Pract. & Dig. Treat.* 6:602, 1955.

Try 'Daprisal' tablets in such conditions as chronic headache, low back pain, arthritis, traumatic pain. You will find 'Daprisal' a very useful agent—especially when the pain is moderately severe.

DAPRISAL *

*a combination of aspirin, phenacetin and the
Mood-Ameliorating Components of Dexamyl**

Smith, Kline & French Laboratories, Philadelphia

*T.M. Reg. U.S. Pat. Off.

WHEN TO CALL IN A COLLECTOR

these doctors continue billing monthly for at least six months. Meanwhile, they encourage the patient to set a probable date for payment. If at that time he's demonstrably on his feet again and still refuses to pay, they consider turning the account over to an agency.

About Deadbeats

Of course, there are always a few deadbeats. If you suspect a debtor of being one, you can often get an impartial appraisal of his ability to pay from the local affiliate of the International

Association of Credit Bureaus.[®] For three or four dollars, the I.A.C.B. member will give you a quick report on the delinquent's payment record; his bank accounts; his history of suits and judgments, if any; and his income.

4. *You've sent your bills promptly and regularly.* Two or three months after the date of your first statement (or the patient's last part-payment), it's a good idea to send him a delinquent notice. If this doesn't get

*Formerly the National Association of Credit Bureaus and still listed as such in many phone books.

and convalescence—

Saturation Dosage of water-soluble vitamins B and C

ALLBEE[®] with C

The highest ascorbic acid content (250 mg.) of any water-soluble vitamin capsule

In each capsule:

Thiamine hydrochloride	15 mg.
Riboflavin	10 mg.
Calcium pantothenate	10 mg.
Nicotinamide	50 mg.
ASCORBIC ACID	250 mg.

A. H. ROBINS CO., INC. RICHMOND 20, VA.

Robins

*only promoted only...
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*easy on the
pocket book!*

For Patients Suffering From

Weak Arch...



Prescribe Dr. Scholl's Arch Supports in cases requiring mechanical relief from Foot Arch Trouble of any kind. The patient will be properly fitted and the Supports adjusted as the condition of the foot warrants, at no extra cost. This nation-wide service is available at many leading Shoe and Dept. Stores and at Dr. Scholl's Foot Comfort® Shops in principal cities.

Dr. Scholl's ARCH SUPPORTS

Schering SCHERING

C O R P O R A T I O N

DIVIDEND No. 9

The Board of Directors has declared a regular dividend of Twenty-five cents (\$0.25) and an extra dividend of Twenty-five cents (\$0.25) a share on common stock payable February 17, 1956, to stockholders of record February 6, 1956.

M. J. FOX, Jr.
Treasurer

Bloomfield, N. J.
January 24, 1956

"Illuminated Reflecting
Letterized Signs"

Fluorescent Lighted
Visible Day & Night
All Aluminum &
Stainless Steel. Sign
Panel 6" x 22" - \$98.
Effective, Dignified.
White lettering on
black background.

WRITE
FOR CATALOG
No. 44



SPENCER INDUSTRIES

117 S. 13th STREET, PHILADELPHIA, PA.

CALL A COLLECTOR

results within a month, have your secretary write or telephone him at fifteen-day intervals. Object: to obtain either a promise to pay or an explanation of nonpayment.

Warn Him First

If there's still no action by the fourth or fifth month, it's probably high time to mail a "final notice." The patient is now warned that payment is expected within, say, ten days. And he's given to understand that if he doesn't comply, your bookkeeper (*not* you) insists that the account be put in the hands of a collection agency.

5. You've tried to trace the debtor who has apparently disappeared. It's worth a few phone calls to save the extra charge agencies make for locating "skips." Your aide should get in touch with at least some of these possible sources of information: the missing individual's former landlord; his last employer; his closest relative; and the person, if any, who referred him to you.

6. You've made reasonably sure that there's no chance of a malpractice suit. Says one experienced collector: "If the patient has threatened such a suit, it's best to withhold collection

when they can't stop coughing...
...when they're away from home.

Expectorant

When public embarrassment adds to the annoyance of a persistent cough, your patients will be grateful for BENYLIN EXPECTORANT. Corrective rather than suppressive in action, BENYLIN EXPECTORANT provides selected demulcent and expectorant agents, plus the potent antihistaminic antispasmodic Benedryl® hydrochloride. Rapidly reducing frequency and severity of cough occurring with colds or allergic disorders, BENYLIN EXPECTORANT soothes irritated respiratory mucosa, makes cough looser and more productive, relaxes bronchial spasm, and relieves nasal stuffiness, sneezing, and lacrimation.

BENYLIN EXPECTORANT contains no narcotics...and does not depress the respiratory center. Its pleasant raspberry flavor appeals to patients of all ages.

BENYLIN EXPECTORANT contains the following ingredients:
Benedryl hydrochloride (diphenhydramine hydrochloride)
Ephedrine Bitartrate
Ammonium Chloride
Salicycylate
Chlorophorm
Menthol
Aniseed

DOSAGE: Adults: Take 2 teaspoons every three hours. Children: Take 1/2 to 1 teaspoon every three hours. Chlorophorm, Aniseed, and Menthol may cause nausea. Salicycylate may cause diarrhea.

PARKER, DAVIS & COMPANY • DETROIT, MICHIGAN





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MERATRAN Profile

OVERWORKED, DEPRESSED*

Sex: Male Age: 38 Occupation: Railroad engineer

Chief Complaint: fatigue, anorexia, sleeplessness.

Symptoms: fast pulse, restless movements, nervous speech habits.

Observations: bouts of depression and discouragement seemed to date from time of release from military service, recurring when work became heavy.

Treatment: Meratran 6 mg. daily, gradually reduced over 60-day period. (Previous sedative and anti-spasmodic therapy only partially successful.)

Response: felt fine, good spirits, appetite excellent, pulse down from 112 to 84.

Results: Improved - no signs or symptoms of original complaint.

One more case in point for

Meratran

Pipradrol Hydrochloride

in functional fatigue and mild depression

Meratran restores your emotionally tired and depressed patients to their usual level of alertness, interest and productivity.



In doses individualized to the patient, Meratran produces a subtle, comfortable onset of action, prolonged effectiveness, and well-being without jitters or apprehension.

There is no significant effect on blood pressure or respiration, little or no insomnia, no effect on normal appetite, no tolerance or drug habituation; wide range of safety.

Dose: 6 mg. daily, adjusted downward to patient need.

Merrell

Other exclusive products
Signal Merrell research

THE WILLIAM S. MERRELL COMPANY
New York • CINCINNATI • St. Thomas, Ontario

*Courtesy from the clinical files of an eminent physician; please professionally advised.

Overworked,
Depressed

Everything handy— only for you



Invincible's exclusive concealed safe unit

Maximum protection for valuable papers, confidential records, narcotics, drugs—keeps them available only to you and your associates.

Variety of sizes
Invincible Filing Cabinet with safe unit. Desk-high, counter-high, four-drawer sizes. Letter or legal size. Optional general lock.

See your dealer or write



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Checkerede® COAT AND HAT RACKS



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CALL A COLLECTOR

pressure until the statute of limitations* has run out—regardless of whether the facts warrant such a suit."

To sum up: If you believe you've made a thorough and conscientious effort to collect a long-overdue bill, you can think seriously about turning it over to an agency. But before actually doing so, take time to double-check your collection efforts. Ask yourself the following questions:

Quick Self-Test

¶ Do I know who's responsible for the bill?

¶ Does he understand clearly all charges?

¶ Am I sure he *can* pay now? Have I offered him a chance to pay on a later date, if necessary?

¶ Has my office mailed regular monthly statements and followed up with letters or phone calls, plus a "final notice"?

¶ If the debtor has moved, have I made some effort to trace him?

¶ Is there a chance of a malpractice suit if I press for payment?

END

*Generally, the statutory limit on malpractice suits is shorter than the statutory limit on suits for nonpayment of bills. The former is often two or three years; the latter, longer than that. But since state laws vary, better check locally before turning over a borderline account to an agency.

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every blood-building factor your anemic patient may need...in just one **ROETINIC®** capsule daily



for all treatable anemias:
each ROETINIC capsule con-
tains therapeutic amounts of
all known hematopoietic factors.

Each ROETINIC capsule contains:

Intrinsic Factor-Vitamin	
B ₁₂ Concentrate	1 U.S.P. Oral Unit
Folic Acid	2 mg.
Ferrous Sulfate, Exsiccated	400 mg.
Ascorbic Acid (C)	100 mg.
Molybdenum Oxide (as the Trioxide)	1.5 mg.
Cobalt (as the Gluconate)	0.5 mg.
Copper (as the Gluconate)	0.5 mg.
Manganese (as the Gluconate)	0.5 mg.
Zinc (as the Gluconate)	0.5 mg.

Supplied: Bottles of 30 and 100 soft, soluble capsules.

Need more than a hematinic? HEPTUNA® PLUS provides hematopoietic factors plus vitamins A and D, the entire B complex and 10 important minerals.



Chicago 11, Illinois

What Qualifies a Doctor To Do Surgery?

[CONTINUED FROM 105]

DR. DETAR: I think every man should be judged individually on his experience and professional capacity. Typically, if a man has done fifty appendixes; if he has been watched by the chief of surgery; if it's felt that he is capable of handling anything that comes up in that

operation—then he ought to be allowed to handle it.

DR. McKITTRICK: Well, suppose that man is privileged, and he has done fifty appendectomies, and he opens up a belly and runs into a cancer of the cecum. What should he do then?

DR. DETAR: He ought to pray! . . . I wouldn't be there unless I were able to take care of that carcinoma or unless I had adequate consultation available.

END



"Who was it who said you can't eat your cake and have it, too?"

NOW—EFFECTIVE STEROID HORMONE
THERAPY OF RHEUMATIC AFFECTIONS
WITH GREATER SAFETY AND ECONOMY

PABALATE-HC

Robins

*Pablate with
Hydrocortisone*

Clinical evidence indicates that, in Pablate-HC, the synergistic antirheumatic effects of hydrocortisone, salicylate, para-aminobenzoate, and ascorbic acid achieve satisfactory remission of symptoms in up to 85% of cases studied

- with a much higher degree of safety
- even when therapy is maintained for long periods
- at significant economy for the patient

Each tablet of Pablate-HC contains 2.5 mg. of hydrocortisone — 50% more potent than cortisone, yet not more toxic.

FORMULA
Per tablet
Cortisone (alcohol) 2.5 mg.
Sodium salicylate 0.3 Gm.
Sodium para-aminobenzoate 0.3 Gm.
Ascorbic acid 500 mg.
DIRECTIONS: Two tablets four times daily.
Medical information on request.

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FOR YOUR
PRESCRIPTION
NOW

A. H. ROBINS CO., INC., RICHMOND 26, VIRGINIA
Ethical Pharmaceuticals of Merit since 1878

Cut \$500 From Your Tax Bill

[CONTINUED FROM 114]

trust officers hesitated to recommend short-term trusts.

2. The trust ties up a large amount of principal for ten or more years. In addition, it requires the services of a trustee who may have to be paid a modest annual fee.

3. The trust also necessitates careful record-keeping, to show allocation of the trust's income for income-tax purposes. Then,

too, the trust document itself must be carefully drawn up by a qualified adviser. An improperly drawn document could bring heavy tax penalties later on.

To my mind, those are surmountable stumbling blocks. I believe that the short-term trust provisions of the latest tax code offer the moderately prosperous physician a major tax break—such a big break, in fact, that Congress may soon revise the law to lessen its attractiveness.

So I'm taking no chances: I've already set up a trust for my 8-year-old son.

END

How a Short-Term Trust Can Cut Your Tax Bill

If ten years' income from property totals:	An individual* will keep, after taxes:	A trust will keep, after taxes:	A single beneficiary will keep, after taxes:
\$10,000	\$5,300	\$ 8,200	\$ 9,380
15,000	7,950	12,200	13,480

*Figures are for a physician in the 47 per cent tax bracket—e.g., a married man filing a joint return on taxable income of \$28,000 plus.



A N A T O M Y O F D I S E A S E

*Within
minutes...*

**effective
antitussive
action**

**when you
prescribe**

TUSSAR

TUSSAR controls even obstinate, hacking coughs symptomatically

TUSSAR gives mild expectorant and exceptional soothing action

TUSSAR contains a superior antihistamine—prophenpyridamine maleate

TUSSAR is combined with dihydrocodeinone bitartrate—approximately six times as potent as codeine, allowing for lower dosage

TUSSAR is easy to take because of its pleasant flavor

16 oz. and gallon bottles

If desired, ammonium chloride, potassium iodide, or ephedrine can be added to Tussar.

Each fluidounce of Tussar contains:	
Dihydrocodeinone Bitartrate.....	1/8 gr.
Warning—may be habit-forming	
Potassium Gusiacol Sulfonate, N.F.	8 gr.
Sodium Citrate, U.S.P.	13.2 gr.
Citric Acid, U.S.P.	2 gr.
Prophenpyridamine Maleate (10 mg./teasp., 5 cc. medicinal)	1 gr.
Chloroform, U.S.P.	2 minimis
Methylparaben, U.S.P.	0.1%
Flavor, sweetening, aroma, vehicle	



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THE ELECTRIC TRINITY COMPLETE.



**DR. CRAMP'S
FLUID LIGHTNING!**

IS A CERTAIN and almost INSTANTANEOUS cure for Head-ache, Neuralgia, Tic Doloureux, Tooth-ache, Ear-ache, and all other pain and suffering having their origin in a derangement of the nervous system. It leaves no scars! It leaves no stain! It is cleanly and easily applied! It is compact and portable. It is always ready for use, and is the cheapest medicine extant; from two to five drops are sufficient.

Warshaw Collection of Business Americana

lightning cure

Although machines and "galvanic batteries" were inconvenient and expensive, electricity had been used for years in treating nervous diseases. It remained for Dr. Cram to devise a method by which electricity could be prepared and preserved in cheap and popular form. "Ben Franklin has captured the Lightning," said one advertisement, "Morse has harnessed the Lightning, and Cram has bottled it!" The price was \$5.00 for six bottles — reasonable enough for lightning.

Today — a century later — effective pharmaceutical specialties and biologicals have stolen the thunder from Dr. Cram's lightning. And because modern drugs are too numerous for easy recall, PHYSICIANS' DESK REFERENCE offers comprehensive data in concise, easy-to-use form, to save you time. As for fluid lightning, it now costs considerably more and it isn't sold in drug stores.

PDR

PHYSICIANS' DESK REFERENCE

published by Medical Economics, Inc., Oradell, N. J.

• action & uses • dosage • contra-indications • product form & packaging

News

[CONTINUED FROM 23]

of their endowments in common stocks.

That's the finding of Vance, Sanders and Company, a distributor of mutual funds. Its poll of thirty-eight of the nation's best-known schools reveals that only one of them now has as little as 42 per cent of its money in common stocks.

At the other end of the scale, two of them have put nearly 80 per cent of their assets in such investments.

What's more, it looks like a trend: The colleges' average common stock-investment has reportedly increased 30 per cent in the past decade.

What Doctors Can Do About Absenteeism

How much does absence from the job because of illness cost America annually? Between \$5 billion and \$10 billion, says a new study by the Research Council for Economic Security.

This total takes into account only loss of products and services. "The direct cost to the employees also is considerable," the Council adds. "The data to date indicate an average net medical-care cost of \$150 per prolonged absence,

suggesting a total bill of \$180 million per year. This is the net cost to the workers after receipt of all benefits under hospitalization, surgical, and medical-care insurance."

What to do about it? Among other things, the Council suggests that a company medical program "should include periodic medical examinations and follow-up of illnesses . . .

"The prevention and control of absenteeism . . . is not possible . . . if the program is confined to the maintenance of a first-aid station or is limited to dealing only with [employment]-connected disabilities."

Insurance Examiners Told How to Succeed

Ever wonder what it is that life insurance companies look for in their medical examiners? The doctor the companies like best appears to be the man who helps them sell more insurance.

Sound strange? Not as Leland T. Waggoner, assistant sales manager of Mutual of New York, explains it.

In a booklet entitled "A Road Map for the Medical Examiner," he says: "Doctors own more life insurance than any other group in the country. It is only natural that they like to see their insurance applicants, and possibly their future patients, have the advantages of a

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99% of your patients will say...

"Meritene® tastes good!"

WHOLE PROTEIN SUPPLEMENT

(as good as ice cream!)

Why so much emphasis on taste? Because, simply stated, there is no value in any nutritional product—regardless how good the analysis looks—if it is not acceptable to the patient.

MERITENE Whole Protein Supplement is acceptable to patients because of its pleasant ice-cream-like taste. (Try it yourself!) And it's easy to prescribe, easy to administer, and economical for patients who use it at home.

MERITENE mixes with milk in seconds (and stays mixed) for ideal high protein supplementation. One 8-ounce MERITENE Milk Shake provides over one quarter the N.R.C. Daily Dietary Allowances for protein and all essential vitamins and minerals.

MERITENE has been widely used by doctors and dietitians ever since its introduction in

A product of

THE DIETENE COMPANY

MINNEAPOLIS 8, MINNESOTA

1940. Available at all drugstores in 1 and 5 lb. cans, chocolate or plain flavor. (1 lb. retails at only \$1.69—institutional size 25 lb. cans as low as 69¢ per pound on direct order from Minneapolis.)

MORE NUTRITIVE THAN EGGNOG

	8 oz. MERITENE MILK SHAKE	8 oz. EGGNOG*
Protein.....	12.5 gm.	14.5 gm.
Fat.....	2.5 gm.	2.7 gm.
Carbohydrate.....	28.5 gm.	27.7 gm.
Iron.....	.12 gm.	.12 gm.
Calcium.....	.58 gm.	.53 gm.
Phosphorus.....	.38 gm.	.35 gm.
Vitamin A.....	230 IU	205 IU
Thiamine.....	.77 mg.	.74 mg.
Biotin.....	.001 mg.	.001 mg.
Ascorbic Acid.....	2.37 mg.	1.72 mg.
Vitamin B.....	.041 mg.	.031 mg.
Dihydroxyacetone.....	.001 mg.	.001 mg.
Cobalamin.....	.001 mg.	.001 mg.

*Average nutritive value from Beale & Chown, 1948 Ed. 1948



FREE 1 LB. CAN

MAKE YOUR
OWN TASTE
TEST

CLIP AND MAIL TODAY!

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3017 Fourth Ave. So., Minneapolis 8, Minnesota
Please send me a FREE one-pound can of MERITENE, plus a supply of comprehensive MERITENE Diet Sheets.

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Address _____

City _____ Zone _____ State _____

INVOLUTION of LESIONS

in PSORIASIS

RIASOL

The untreated lesions of psoriasis undergo *progressive evolution* through the stages of tiny discrete papules, erythema, scaliness, peripheral outgrowth, infiltration and elevation, and finally coalescence of smaller plaques to make large configurations (Ormsby and Montgomery*).

When psoriasis is treated with RIASOL the stages are reversed and the lesions undergo *progressive involution*. Infiltration and elevation are reduced, the outlines of the lesions gradually recede, scaliness disappears, and the final stage consists of slow fading reddish spots.

With continued applications of RIASOL all visible vestiges of psoriasis finally vanish. Such remissions of the disease may last for many months or even years.

RIASOL contains 0.45% mercury chemically combined with soaps, 0.5% phenol and 0.75% cresol in a washable, non-staining, odorless vehicle.

Apply daily after a mild soap bath and thorough drying. A thin, invisible economical film suffices. No bandages required. After one week, adjust to patient's progress.

RIASOL is supplied in 4 and 8 fl. oz. bottles at pharmacies or direct.

*Ormsby, O. S. and Montgomery, H., *Diseases of the Skin*, 8th ed., 1954.

Test RIASOL Yourself

May we send you professional literature and generous clinical package of RIASOL. No obligation. Write

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After Use of Riasol

RIASOL FOR PSORIASIS

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good life insurance program. If, in [sincerely recommending the purchase of insurance], you . . . also recommend your company and the agency handling the case, you have been even more helpful . . ."

The booklet points out that the doctor can also be helpful by (1) being on time for appointments; (2) letting agents know when adverse medical reports must be issued; and (3) *not* telling applicants they're in good physical condition when he knows they must be issued special rated-up policies.

Deductible Clause Urged For Health Insurance

The trend toward deductible clauses in health insurance is apparently gaining impetus. There's growing public acceptance of new-style policies that require the patient to pay a fixed amount of the initial expense of illness, says Charles N. Walker of The Lincoln National Life Insurance Company. Chief reason for public acceptance of such policies: Their coverage provides more benefits and costs "a third less" than the conventional contract.

The average American family, Walker observes, "tends to purchase whatever hospital insurance \$120 a year will buy—regardless of whether or not the benefits . . . are adequate . . . Using my own company's forms as an example, a premium of \$120 will buy, for a family of four persons in the

Vitamins at a
truly therapeutic
level for all
stress conditions

Theron (STUART)

Tablets:	Liquid:
30's and 100's	4 oz. bottles
Dose:	Dose:
1 tablet daily	1 teaspoonful daily

ease the . . .

**burdened heart
edematous tissues
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**active diuretic
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*Early
Diagnosis
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= High Cancer Cure Rates

The General Practitioner can obtain free, lifesaving information on early detection, diagnosis and treatment from the American Cancer Society.

Professional Films



A film series* of 24 clinical teaching conferences, entitled "Physicians' Conferences on Cancer," plus about 150 other films on detection, diagnosis and treatment.

Journal Cancer



Bimonthly Professional Journal giving latest results and applications of clinical cancer research.

CA—A Bulletin of Cancer Progress

Bimonthly digests and abstracts of current articles, feature articles, questions and answers, news items, clinical conferences, etc.



Monograph Series

Series of textbooks on cancer by site, emphasizing detection and diagnosis, written by outstanding clinicians.



For information about these and other materials write your Division of the American Cancer Society.

*Approved by the American Academy of General Practice for Informal Study Credit.



AMERICAN CANCER SOCIETY

younger age group, \$7 daily hospital benefit... If a [\$100] deductible form is used, it will buy \$12 per day."

Health insurance is generally criticized, he points out, for its "failure to cover a sufficiently high portion of the medical bill... Deductible insurance is a positive method [of answering] this criticism." Only with such policies, he maintains, can patients be covered for "the risks [they] can least afford to incur." For example:

The usual policy offers a daily benefit that starts with the first day of hospital confinement and continues up to ninety days. Though such coverage may seem adequate,

it's "small comfort to a man who must spend 200 or 300 days in a hospital. But if we take just one day off the front of this benefit—start with the second day instead of the first—we can provide more than 200 days' coverage, instead of ninety, for the same price. If we take five days off the front, we can provide more than two years' coverage. Doesn't this do a better job of protecting the policyholder against expenses he cannot afford?"

His own company's experience with the new type of insurance proves its effectiveness, says Walker. Lincoln National first introduced deductible coverage early last



Hundreds of leading hospitals use Americaine Aerosol as the routine spray-on relief for their obstetrical and gynecological patients. Only Americaine (Aerosol, Ointment, and Liquid) contains 20% dissolved benzocaine in a bland, water-soluble vehicle.

Also useful for burns, sunburn, dermatoses, exanthemas, debridement of wounds, cuts, abrasions, etc. to relieve surface pain and itching.

AVAILABLE: 5.5 oz. size for hospital and prescription. 11 oz. size for office use. ALSO: Americaine Anesthetic Ointment (same potent formula).

HOW TO COMFORT THE OB PATIENT . . .

AMERICAINÉ AEROSOL

For Painful Post-Episiotomies . . .

Hemorrhoids . . .

Post-Hemorrhoidectomies . . .

Gynecological Procedures

- Relieves pain in 2-3 minutes
- Relief lasts 4-6 hours
- Bacteriostatic . . . Sanitary
- Quick, easy to apply
- No sensitivity in 1866 published cases.

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AUTOMATIC SPRAY TOPICAL ANESTHETIC

ARNAR-STONE LABORATORIES, INC. Mount Prospect, Illinois

MEDICAL ECONOMICS · MARCH 1956 311



New suppositories eradicate urethral infection and pain

The suppository this patient inserted at home keeps her comfortable all day and allows her to follow her normal routine

new—the only urethral suppository

fast—prompt relief of pain and burning

sure—the nitrofuran, FURACIN, eradicates most

bacteria common to urethral infections

*safe—irritation rare in over 340 reported cases**

*proved—"the suppository method of medication has proved its worth"**

PRESCRIBE: for bacterial (granular) urethritis; for topical anesthesia and prophylaxis of infection before and after instrumentation

FORMULA: 0.2% FURACIN (brand of nitrofurazone) and 2% diperodon · HCl in a water-miscible base. Sealed in foil. Box of 12.

to prevent cross-infection

Use the urethral suppositories with **FURACIN vaginal Suppositories** to prevent urethrovaginal cross-infection.

FORMULA: 0.2% FURACIN (brand of nitrofurazone) in a water-miscible base. Sealed in yellow foil. Box of 12.

*Youngblood, V. H.: J. Urol. 70:926, 1956.

EATON LABORATORIES, Norwich, N. Y.



FURACIN® urethral SUPPOSITORIES

NITROFURANS a new class of antimicrobials
neither antibiotics nor sulfas

year. Eight months later, such contracts accounted for nearly half the firm's hospital insurance sales.

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Addressing envelopes at statement time might become less of a chore for your aide with this new low-cost addressing unit. The manufacturer claims it can reproduce 500 patients' addresses in an hour from typed master cards. Several similar units are now on the market.

The master card itself is easily prepared: The aide simply puts a special carbon sheet behind the master and types out the name and address.

This makes a carbon impression on the back of the card; the impression can then be transferred to an envelope by means of a hand roller, as shown below. And the card can apparently make up to 100 reasonably good copies before it wears out.

Cost of the complete kit runs in the vicinity of \$30. END



HAND ROLLER reproduces 500 patients' addresses an hour from typed cards.



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improves protein utilization
restores healthy appetite
accelerates weight gain
encourages normal growth

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Supplied: In 46 Gm. bottles with special Lactofort measuring spoon enclosed.

a dry stable powder • odorless

LACTOFORT the complete dietary supplement
2 measures (2.3 Gm.) of Lactofort supply:

L-Lysine Monohydrochloride	660 mg.*
Vitamin A Acetate.....	3,750 U.S.P. units
Vitamin D	1,000 U.S.P. units
Thiamine Mononitrate	0.75 mg.
Riboflavin	1.25 mg.
Niacinamide	7.5 mg.
Vitamin B ₁₂	3.5 mcg.
Folic Acid	0.25 mg.
Ascorbic Acid	75 mg. <small>(from Sodium Ascorbate)</small>
Pyridoxine Hydrochloride	0.75 mg.
Calcium Pantothenate	7.5 mg.
Iron (elemental)	7.5 mg. <small>(from Iron Ammonium Citrate Green)</small>
Calcium (elemental)	130 mg. <small>(from Calcium Gluconate)</small>

*Equivalent to 500 mg. L-lysine.

• tasteless • readily soluble

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